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Primary Care for Urban Core Disadvantaged Patients: An Annotated Bibliography

Sharon Manson Willms
Joanna M. Bates

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PRIMARY CARE FOR URBAN CORE DISADVANTAGED PATIENTS:
An Annotated Bibliography

Sharon Manson Willms, Ph.D., RSW
Joanna M. Bates, MDCM, CCFP

INTRODUCTION

The urban core disadvantaged patient presents a complex set of problems related to access to medical care, socio-economic issues, mental health, health status and medical case mix. This annotated bibliography presents a selection from the literature pertaining to this population subdivided into user sub-groups, including homeless, refugees, and categories of presenting problems such as mental illness, HIV disease and alcohol and substance abuse.

1) **Aday, Lu Ann (June 1975) "Economic and Noneconomic Barriers to the Use of Needed Medical Services," *Medical Care*, Vol. XIII, No. 6: 447-456.**

Access; medical care; poverty.

This paper introduces an index of access to medical care that describes the use of services relative to the actual need for care. Findings on this particular measure suggest that, contrary to the implications of much of the existing literature, the poor continue to use fewer service relative to the disability they experience than do the nonpoor. Further, despite the advent of publicly financed economic solutions to these access differentials, Medicaid and Medicare, in particular-organizational barriers to entry, such as the long queues to obtain services and long travel times to care in some areas, still exist. The implications of these findings for the evaluation of existing and proposed national health policy efforts are discussed.

2) **Aiken, Linda H.; Lewis, Charles E.; Craig, John; Mendenhall, Robert C.; Blendon, Robert J.; & Rogers, David E. (1979) "The Contribution of Specialists to the Delivery of Primary Care," *New England Journal of Medicine*, Vol. 300, No. 24: 1363-1370.**

Specialist; primary care.

Despite increased numbers of medical-school graduates and opportunites for "primary-care" specialty training since the mid-1960's, many have believed that the shortage of physicians delivering generalist care will continue through the 1980's. Missing however, is solid information on the role of physician specialists in providing such care. Two national studies have shown that one of every five Americans now receives continuing general medical care from a specialist physician. The study suggests that, despite the current shortage of generalist-physician services, continuing specialist participation in primary care will lead to sufficient generalist medical services by the mid-1980's. Whether specialist participation is the most appropriate or cost-effective way to improve access to such care is unclear. However, until this question is resolved, more governmental regulation of graduate medical education may by unwise. Offering all physicians, regardless of specialty, more primary-care experience during residency training might better deal with this aspect of American medical practice.

3) **Alperstein, Garth; Rappaport, Claire; & Flanigan, Joan M. (September 1988) "Health Problems of Homeless Children in New York City," *American Journal of Psychiatric Health*, Vol.78, No.9: 1232-1233.**

Homelessness; children; health problems

The authors reviewed the outpatient medical records of 265 homeless children less than 5 years of age in New York City and compared them with children of similar low socioeconomic status (SES) attending the same pediatric clinic. The frequency of health problems among the homeless children, including delayed immunizations, elevated blood lead levels, the rate of admission to hospital,and the rate of child abuse and neglect reports, exceeded those for the comparison group.

4) **Auslander, Gail K. (1988) "Social Networks and the Functional Health Status of the Poor: A Secondary Analysis of Data From the National Survey of Personal Health Practices and Consequences,"** ***Journal of Community Health*****, Vol. 13, No. 4: 197-209.**

Social networks; health status; poverty

This study uses data from the Wave I of the National Survey of Personal Health Practices and Consequences (N=3025) to examine the relationship between social networks and the health status of the poor. No single category of networks was found to be consistently predictive of health status among the poor. The number of close friends, satisfaction with number of close ties, frequency of contact with network ties and church attendance were all significantly related to health status, but in no case were sufficient to bring health status levels of the poor up to the level of the nonpoor.

5) **Bachrach, Leona L. (1980) "Overview: Model Programs for Chronic Mental Patients,"** ***American Journal of Psychiatry*****, Vol. 137, No. 9: 1023-1031.**

Chronic; mental illness; patients; model programs

Model programs for chronic mental patients may be viewed from four perspectives: evaluation of individual programs, commonalities in successful programs, generalizability and reproducibility of specific programs, and relevance of model programs to problems of service delivery in mental health systems. Although successful model programs share certain common structural elements, such programs cannot be readily reproduced or generalized. Having limited value for the problems of service delivery in mental health systems, model programs are best seen as experimental efforts, not as solutions. Strategies for translating model-derived knowledge into systems-related action are needed.

6) **Bachrach, Leona L. (1974) "Developing Objectives in Community Mental Health Planning,"** ***American Journal of Psychiatric Health*****, Vol. 64, No. 12: 1162-1163.**

Mental Health; community planning

The objectives of interagency community mental health plans should be proposed with due recognition for three characteristics. Relevancy:the objective must have direct relationship to the long term goals commonly shared by the various service agencies. Practicability:the objective must be capable of realization through the resources at the disposal of the agency proposing it. Measurability:the objective must be capable of being measured, either directly (by counting) or indirectly (by translation into comparative terms other than numbers). Such considerations will make it possible to formulate a community mental health plan which combines unity in purpose with diversity in programs.

7) **Bachrach, Leona L. (1984) "Asylum and Chronically Ill Psychiatric Patients,"** ***American Journal of Psychiatry*****, Vol. 141, No. 8: 975-978.**

Primary care; chronic; mental illness

The decision to change the primary locus of care for chronically ill psychiatric patients from the state mental hospital to the community has often set off a chain reaction of consequences. Notably, reducing the role of the institutions has frequently resulted in destroying needed sanctuary for some patients. The author discusses the relationship between deinstutionalization and the function of asylum and examines the relevance of three planning principles; functional equivalence, cultural relevance, and potential trade-offs to the need of chronically ill psychiatric patients for asylum.

8) **Bassuk, Ellen & Gerson, Samuel (1980) "Chronic Crisis Patients: A Discrete Clinical Group,"** ***American Journal of Psychiatry*****, Vol. 137, No. 12: 1513-1517.**

Chronic; patient characteristics; mental illness

Patients who made repeated visits to a psychiatric emergency ward and who were studied appeared to comprise a discrete clinical group characterized by a distinct symptom profile, common psychiatric history, and similar styles of interacting with caretakers. They generally did not differ from nonrepeater patients with regard to acute symptomatology but were hospitalized more frequently. They were generally negativistic, had a lengthy psychiatric history consisting of multiple inpatient hospitalizations and current outpatient treatments, and had difficulty establishing rapport with the emergency ward therapists, often evoking intense feelings of dislike. The authors offer an approach to the management of these patients based on an understanding of their cycle of seeking and rejecting help.

9) **Bassuk, Ellen L; Ruben, Lenore; & Lauriat, Alison S. (September 1986) "Characteristics of Sheltered Homeless Families,"** ***American Journal of Psychiatric Health*****, Vol. 76, No. 9: 1097-1101.**

Homelessness; families; patient characteristics; mental health

To describe the characteristics of homeless families, we interviewed 80 homeless mothers and 151 children living in 14

family shelters in Massachusetts (two-thirds of the shelters in the state). Ninety-four percent of the families were headed by women, 91 percent were on AFDC (aid to families with dependent children), with twice as many as the state average having been on AFDC for at least two years; most had long histories of residential instability. Although 60 percent had completed high school, only a third had worked longer than one month. One-third of the mothers reported having been abused during their childhood, and two-thirds had experienced a major family disruption. At the time of the interview, almost two-thirds either lacked or had minimal supportive relationships and one-fourth of these named their child as the major support. Eighteen mothers were involved with the Department of Social Services because of probable child abuse of neglect. Seventy-one percent of the mothers had personality disorders. In contrast to many homeless adult individuals, however, deinstitutionalized persons or those suffering from psychoses were not overrepresented. About 50 percent of the homeless children were found eto have developmental lags, anxiety, depression, and learning difficulties, and about half required further psychiatric evaluation. Two-thirds described housing and social welfare agencies as not helpful. Given the many serious problems of the mothers and the difficulties already manifested by their children, comprehensive psychosocial and economic interventions must be made to interrupt a cycle of extreme instability and family breakdown.

10) **Bassuk, Ellen L. (1984) "The Homelessness Problem," *Scientific American*, Vol. 251, No. 1: 40-45.**

Homelessness; emergency shelters

This article looks at the increasing numbers of homeless people in American streets. There is indications that a large majority of these people suffer from mental illness, ranging from schizophrenia to severe personality disorders. The most obvious and accepted solution to the homeless problem is to establish more shelters but this finding has disturbing implications. Although the food and refuge they offer saves lives, most of these shelters offer no psychiatric care and thus do not meet the needs of many of the homeless. The author also reviews some of the major government policies that inadvertently contributes to increasing the numbers of the homeless, such as their effort to reform and reduce the Social Security Disability Insurance program in March of 1981. As well, the author studies the effects of the shortage of affordable housing and the deinstutionalization of the mentally ill which both lead to amassing more homeless people.

11) **Bean, Gerald J; Stefl, Mary E., & Howe, Steven R. (Sept-Oct 1987) "Mental Health and Homelessness, Issues and Findings," *Social Work*, Vol. 32, No. 5: 411-416.**

Homelessness; mental health

Increased attention to homelessness in America has prompted speculation about causes, and mental health policies and programs are alleged to have contributed to this social problem. This article presents data from an epidemilogical study of 979 homeless people in Ohio in which just under one-third of the respondent sample was found to be in need of mental health services. Issues important to both clinicians and epidemiologists working with homeless people are discussed.

12) **Bellin, Seymour S. & Geiger, H. Jack (1972) "The Impact of a Neighborhood Health Center on Patients' Behavior and Attitudes Relating to Health Care: A Study of a Low Income Housing Project," *Medical Care*, Vol. X, No. 3: 224-239.**

Health services; health services

A previous paper based on clinic records, showed high levels of utilization of Health Center Services by a low income community, approximating comparable figures for a more affluent population. A great majority of community residents, based on a before-after health survey of a random sample of households, currently report the Health Center as their regular source of health care. Residents make extensive use of not only curative services but also of preventive medical services, e.g., asymptomatic checkups and immunizations. The main focus here is to seek to account for such changes in health behaviors and utilization in terms of two sets of possible explanatory factors: attitudes and circumstances. Attitudes are examined towards health, health care, and sources of such care. In addition, consideration is given to the possible role of several situational factors-time, money, and convenience in influencing patterns of utilization. Significant changes are reported in all attitudes, paralleling changes in utilization of service. A marked decrease also is reported in such potential barriers to use of services as expenditure of time and money. Inferences are drawn about the implication of these findings for health services planning.

13) **Bergner, Lawrence & Yerby, Alonzo S. (1968) "Low Income and Barriers to Use of Health Services," *New England Journal of Medicine*, Vol. 278, No. 10: 541-546.**

Utilization of health services; poverty

The poor in the U.S. receive a disproportionately low share of health services. The barrier of direct cost is not sufficient to explain this underuse, and the advent of Medicare and Medicaid will not erase the existing discrepancies. The failure to inform adequately potential clients of the existence and availability of services is a significant barrier. The organization, administration and conduct of services can be important deterrents to use. The professional health worker must be trained to be able to provide effectively his services in comprehensive programs for the poor and uneducated.

14) **Belcher, John R. (1988) "Rights Versus Needs of Homeless Mentally Ill Persons," *Social Work*, Vol. 33, No. 5: 398-402.**

Homelessness; mental illness

Homeless mentally ill persons have unique patterns of participation in the mental health system. Providing effective intervention and maintaining the rights of such individuals can pose ethical and moral dilemmas for social workers. The interpretation of commitment leglisation and the impact of narrow interpretation of these individuals is examined. Service providers need to weigh clients rights to self-determination against immediate survival needs and the potential mental restoration that could be provided through commitment to a psychiatric hospital.

15) **Brickner, Philip W. & Kaufman, Arthur (1973) "Case Findings of Heart Disease in Homeless Men," Bulletin of New York Academy of Medicine, Vol. 49, No. 6: 475-484.**

Homelessness; men; disease

Clinics have been established in three welfare hotels in the Greenwich Village-Chelsea area to provide care for homeless derelict men. These men are generally among the medically unreached. For reasons of circumstance and personality they fail to seek health care through standard means. Most of the 434 men seen in the clinics were either alcoholics or drug addicts, and the major health problems encountered were related to these forms of abuse. Significant cardiovascular disease was found in 54 men, most of whom had either arteriosclerotic or hypertensive problems. Cooperation from these patients was often poor, but 25% of the men have demonstrated a capacity to remain in long-term treatment for their cardiac problems, and have benefited from the clinic programs at the welfare hotels.

16) **Brickner, Philip W; Scanlan, Brian C.; Conanan, Barbara; Elvy, Alexander; McAdam, John; Scharer Keen, Linda & Vicic, William J. (1986) "Homeless Persons and Health Care," *Annals of Internal Medicine*, Vol. 104, 405-409.**

Homelessness; disease; health care

Health care is generally unavailable for the homeless. This heterogeneous group of men and women, including long-term street dwellers, residents of shelters, the chronically mentally ill, the economically debased, and alienated youth, are subject to a broad range of acute and chronic diseases, intensified by unsuitable living conditions, stress, and socioipathic behavior. Trauma, pulmonary tuberculosis, infestations, and peripheral vascular disease are common problems among the homeless; incomplete and fragmentary medical care permits exacerbation of chronic disorders. Outreach programs imaginatively constructed by teams of physicians, nurses, and social workers can effectively reestablish and maintain health services for these disenfranchised persons.

17) **Brickner, Philip W.; Greenbaum, Dennis; Kaufman, Arthur; O'Donnell, Francis; O'Brian, John T.; Scalice, Robert; Scandizzo, John, & Sullivan, Thomas (1972) "A Clinic for Male Derelicts: A Welfare Hotel Project," *Annals of Internal Medicine*, Vol. 77, 565-569.**

Homelessness; men; welfare hotel; medical care

A clinic for 1200 derelict men was conducted for 18 months in a large welfare hotel in New York City to bring medical attention to people who would not otherwise have been seen. The residents of the hotel were generally destitute elderly men, middle-aged chronic alcoholics, and young users of heroin. The staff consisted of three nurses assigned to the unit and eight volunteer physicians. The impact of the experience on these workers was related to their motives. Most of those engaged in the hotel project are now involved in similar work elsewhere.

18) **Buckingham, Robert W. & Lupu, Dale (1982) "A Comparative Study of Hospice Services in the United States," *American Journal of Psychiatric Health*, Vol. 72, No. 5: 455-463.**

Hospice ; health services

In order to document the implementation of the hospice concept in the United States, 24 hospices, in operation at least one year and serving at least 100 patients, were selected from the National Hospice Organization roster to participate in a survey of organization, staffing, funding, services, and population

served. Hospices provide a wide variety of both medical and social services provided by volunteers as well as paid staff.

19) **Buff, Daniel D.; Kenny, James F.; & Light, Donald (1980) "Health Problems of Residents in Single-Room Occupancy Hotels," *New York State Journal of Medicine*, December: 2000-2005.**

Single Room Occupancy (SRO); health problems

The development of SRO (single room occupancy) hotels have formed the latest chapter in the long history of Western society's treatment of individuals. During the research, the author found an agency that offers integrated and rather comprehensive services to all the residents in the SRO hotels where they are located. The agency is the City of New York OCIS (Office of Crisis Intervention Services). It is the conclusion that the OCIS on-site team approach is the best method available at this time to respond to the health needs of SRO residents.

20) **Cafferata, Gail Lee & Kasper, Judith D. (1989) "Family Structure and Children's Use of Ambulatory Physician Services," *Medical Care*, Vol. 23, No. 4: 350-360.**

Ambulatory care; children; family

The purpose of this article is to examine children's use of ambulatory physician services in relation to three dimensions of family life: maternal employment, single-parent versus two-parent households, and the presence of a nuclear or extended family. Data from the National Medical Care Expenditure Survey show that maternal employment has no relationship to children's experience of disability days, and although children of mothers employed full-time are less likely to have physician contact than are other children, this is attributable to a lower probability of seeing a doctor for children in good health (i.e. no disability days). Multivariate analysis confirms that although maternal employment decreases the likelihood of a telephone consultation with the child's physician, children in single-parent families are more likely to see a physician when they have no disability days, than are children in families with two parents present. Children in nuclear rather than extended families do not differ in patterns of use, even when the mother works. Aside from other characteristics that might be expected to affect use (e.g. age, health status, insurance coverage, a usual source of care), there is a clear relationship between the likelihood and volume of use by mothers and children.

21) **Chafetz, Linda (1988) "Perspectives for Psychiatric Nurses on Homelessness," *Issues in Mental Health Nursing*, Vol. 9: 325-335.**

Homelessness; nurses; mental illness; chronic

Homelessness has special significance for nurses who work with the chronically mentally ill. It can be defined in a narrow sense or in more liberal terms:
Application of restrictive or liberal definitions produce widely divergent estimates of the homeless population nationally, and of the mentally ill among them. Social and economic factors have contributed to homelessness for a varied population, but persons with severe psychiatric disorders in urban areas appear to be at particular risk. The homeless mentally ill are diverse in a demographic sense and in terms of clinical problems. However, they present some common treatment issues related to their living conditions. New treatment models may provide some of the support services the chronically mentally ill require, to prevent poverty and isolation in the community. Nurses who work with the homeless can contribute to their well-being as clinicians and as client advocates.

22) **Chafetz, Linda & Goldfinger, Stephen M. (1984) "Residential Instability in a Psychiatric Emergency Setting," *Psychiatric Quarterly*, Vol. 56: 20-34.**

Residential instability; mental health

This paper focuses on the phenomenon of residential instability within a psychiatric emergency setting: its association with clinical status, and its implications for mental health professionals. For this perspective, the authors considered conditions of living at a point in time for a given individual. The authors did not examine the characteristics of populations thought to be habitually affected by these conditions.

23) **Chesteen, Susan A.; Warren, Steven E.; & Woolley, F. Ross (1986) "A Comparison of Family Practice Clinics and Free-Standing Emergency Centers: Organizational Characteristics, Process of Care, and Patient Satisfaction," *Journal Family Practice*, Vol. 23, No. 4: 377-382.**

Family practice clinics; emergency centers; physician-patient encounters

Because of the increasing popularity of free-standing emergency centers as a source of primary care services, this cross-sectional study was conducted to compare four of them with two family practice centers that provided extended hours. A total of 2,339 patient encounters were examined with data obtained from both physicians and patients. The factors that were found to be a basis for discrimination between the two types of practice were the cost of care and the patient's satisfaction with convenience and personal attention from the physicians. The overall average costs were significantly higher for the free-standing centers

($45) as compared with the family practice clinics ($27). Convenience and time factors, including waiting time, time spent with the physician, time to get an appointment, clinic location, and out-of-pocket cost, all produced a higher level of satisfaction for the free-standing clinic patients.

Conversely, the personal concern of the physician and the ability seeing the same physician brought higher levels of satisfaction for the family practice clinic patients. The free-standing emergency center is clearly becoming a significant factor in the delivery of primary care with evidence to suggest that patients are willing to pay a premium for convenience.

24) **Committee on Child Welfare, Ontario Medical Association (September 15, 1987) "Public Policies and the Health of Children," Canadian Medical Assocation Journal, Vol. 137, 481-482.**

Health status; children; poverty; health care

In this issue the evidence that documents the effect of poverty on the health of children is reviewed. It is clear that children from low-income families have poorer indices of health than those at higher socioeconomic levels, higher infant and childhood mortality rates, and higher mortality rates from accidents, violence and certain forms of cancer. The definitive solutions lie beyond the scope of both a physician's practice and the ministries of health. What poor children need is decent housing, recreational facilities, better nutrition and greater support to achieve optimum education potentials.

25) **Cohen, Carl I.; Teresi, Jeanne A.; & Holmes, Douglas (1988) "The Physical Well-Being of Old Homeless Men," *Journal of Gerontology*, Vol. 43, No. 4:121-128.**

Homelessness; men; health care

This study addressed a variety of issues related to the etiology, prevalence, and treatment of physical disorders among aging homeless men. The sample consisted of 195 nonstreet dwellers (177 residing in flophouses, 18 in apartments) and 86 street dwellers on the Bowery in New York City. The sample comprised men aged 50 and older. Bowery men scored worse than an aged-matched sample of community men on all physical health scales, with the greatest differences occurring in the respiratory, gastrointestinal, edema, hearing, hypertension, and ambulatory scales. Frequency of visits by the Bowery men was comparable to that of the community men, and the Bowery men rated their health substantially better than did their counterparts of two decades ago. Poor physical health often appeared to antedate arrival on the Bowery. However, a hierarchical regression analysis identified several variables-stress, unfulfilled needs, being relatively young, institutional/agency contacts-that were associated with current levels of poor health. Identification of these variables pointed to areas that warrant closer attention by clinicians and service providers.

26) **Cohen, Carl I. & Sokolovsky, Jay (1983) "Toward a Concept of Homelessness Among Age Men," *Journal of Gerontology*, Vol. 38, No. 1: 81-89.**

Homelessness; men; Single Room Occupancy; Skid Row

New York City homeless aged men living on the Bowery and in single-room occupancy hotels were contrasted using Bogue's model of skid row social formation. Because of their commonality of being unattached urban males, it had been assumed that they would exhibit similar characteristics and modes of adaptation. It is shown that homeless is not a uniform category, nor can these males always be easily distinguished from the general population. Only sociability criteria differentiated these men as a group from their nonhomeless age peers suggesting the appropriateness of an interactive conceptual framework for homelessness. The ability of these men to adapt to other environments is discussed.

27) **Coulter, Martha L. & Hancock, Tina (1989) "Integrating Social Work and Public Health Education: A Clinical Model," *Health and Social Work*, August: 157-164.**

Social workers; public health programs

In Florida, the need for clinically oriented social workers with expertise in planning and evaluating maternal and child health programs has led to the establishment of a joint master of social work and master of public health degree program. This program has a clinical social work concentration combined with a public health concentration in maternal and child health content, administration, and research design. The philosophy and development of the program, the course content and degree requirements, the field placement content, issues regarding student acceptance and advisement, faculty appointments, and program directions and goals are discussed. Descriptions of both the social work and public health programs that operate the joint-degree curriculum and the differing perspectives are outlined as well as skills that students obtained through their participation in the program.

28) **Cugliani, Anne (1978) "Patterns of Hospital Based Amulatory Care," *Social Science & Medicine*, Vol. 12, 55-58.**

Ambulatory care; utilization of health services; patient characteristics

Blue Cross/Blue Shield of Greater New York conducted a survey of ambulatory services in 135 hospitals during June 1974 encompassing 21 major clinics as well as Emergency Room services in each of the hospitals. A total of 16, 822 patient visits were studied. The most striking variations in the characteristics of patients who made the visits to the 1120 clinics and 133 emergency rooms was the extraordinary utilization by minority groups and females. The variation in district utilization rates explained by differences in ethnicity was found to exceed substantially that explained by per capita income, thus indicating that variation in clinic utilization is more closely associated with ethnicity than with income. As the growth of clinic utilization parallels the declining availability of the family physician in underserved areas so too does the use of the Emergency Rooms for non-trauma reasons reinforce this pattern. Non-white and low-income patients comprised a high proportion of non-emergency cases because of lesser access to private physicians.

29) **Dietrich, Allen J. & Olson, Ardis L. (1986) "Model System of Ongoing Care for Native Americans-a 5-Year Followup," *Public Health Reports*, Vol. 101, No. 2: 184-187.**

Ongoing medical care; Native indians

In 1979, continuing care from a personal physician was identified as a priority at the Indian Health Service site in Zuni, NM, a rural hospital and ambulatory care center serving 7,000 Zuni people. To encourage such care, a system was established that assigned each patient to a regular physician and organized physicians into teams. Three teams, each consisting of three clinicians and other support personnel, served specific geographic regions of the village. Five years later, the ongoing care provided for active randomly selected prenatal, diabetic, and general clinic patients was evaluated. The physician staff of the site had gone through a complete turnover during the previous five years. Based on a chart review for the year prior to patient identification, patients saw their regular physician visits, and their regular physician or his or her team colleague from 71 to 82 percent of the time in all their visits.

30) **Dutton, Diana B. (1979) "Patterns of Ambulatory Health Care in Five Different Delivery Systems," *Medical Care*, Vol. XVII, No. 3: 221-243.**

Ambulatory care; ambulatory settings

Few empirical investigations permit systematic comparison of the impact of widely-varying delivery systems within a single population sample. This study provides such a comparison, describing patterns of ambulatory care among patients using five different systems in Washington, D.C. as regular source of health care: solo practices, fee-for-service group practice, prepaid group practice, public clinics, and hospital outpatient departments or emergency rooms. Comparisons are adjusted statistically to account for major patient group variations, and the results reveal substantial differences among the five systems. Sources used primarily by the poor,hospital outpatient departments, emergency rooms, and public clinics,contained important structural and financial barriers, and had the lowest rates of patient-initiated use. The prepaid system, in contrast, maximized patients' access to both preventive care and symptomatic care, and did not seem to inhibit physician-controlled follow-up care. The results suggest some perverse effects of fee-for-service systems were distributed less equitably relative to both income and medical need than in the prepaid system. These findings have direct implications for policy decisions concerning organizational and financial arrangement for the delivery of ambulatory care.

31) **Dutton, Diana B.; Gomby, Deanna; & Fowles, Jinnet (1985) "Satisfaction with Children's Medical Care in Six Different Ambulatory Settings," *Medical Care*, Vol. 23, No. 7: 894-912.**

Ambulatory settings; physican-patient encounters; children; medical care

This article compares mothers' satisfaction with children's medical care in six widely varying settings: fee-for-service solo and group practices, prepaid group practice, public clinics, hospital outpatient departments, and emergency rooms. Data are from a household survey representing 700 children in Washington, D.C. Satisfaction with the physican's friendliness, competence, and personal care, as well as waiting time, atmosphere, and cost were examined, comparing how satisfaction levels varied in relation to patient characteristics. Satisfaction with interpersonal items was highest in fee-for-service settings, especially solo practice, whereas satisfaction with cost was highest in the public clinics, followed by the prepaid group practice. Previously published comparisons of utilization and health outcomes in the same settings revealed entirely different rankings. Together, these findings illustrate the multifaceted and paradoxical nature of health system performance.

32) **Duff, Raymond S.; Rowe, Daniel S.; & Anderson, Frederic P. (1972) "Patient Care and Student Learning in a Pediatric Clinic," *Pediatrics*, Vol. 50, No. 6: 839-846.**

Ambulatory care; children; student teaching; pediatric clinic

The problems of a random sample of 25 children visiting a general pediatric clinic were physical (12%), psychosocial (36%), and a combination of these (52%). In terms of

management, these problems were simple (20%), moderately complicated (20%), very complicated (36%). The visit resulted in major contributions in 20% and on contribution in 56%. Students rated the teaching exercise as good in 48%, mediocre in 20%, and poor in 32%. Students and families were at least satisfied when the children's difficulties were psychosocial in nature. Such problems usually were not given serious consideration in the clinic. Pediatric specialists were occupied with diseases of primary concern to them while other pediatricians were unpaid, spent minimal time in the clinic, and had a primary interest in private practice. Under these circumstances, no pediatrician could give more than token interest to the complex physical and psychological problems for which help was being sought. This was no match for the services and teaching challenges in the clinics.

33) **Erkel, Elizabeth A. (1980) "The Implications of Cultural Conflict for Health Care,"** ***Health Values*****, Vol. 4, No. 2: 51-57.**

Health care; cross-cultural differences

Financial accessibility and geographic availability of health care will not necessarily assure the poor and ethnic minorities high quality, comprehensive health care because of the culturally unacceptable care plans frequently provided for them. Research substantiates that there is a great potential for cultural conflict in the health care provider-consumer relationship and that public and private consumers are viewed and treated differently by providers. Unless health care plans are congruent with consumers' lifestyles and needs, they will not be implemented. Thus, health care providers must become familiar with the cultural beliefs, values, and practices of the diverse ethnic classes in their communities in order to provide culture-specific health care to their patients.

34) **Fetter, Robert B.; Averill, Richard F.; Lichtenstein, Jeffrey L. & Freeman, Jean L. (1984) "Ambulatory Visit Groups: A Framework for Measuring Productivity in Ambulatory Care,"** ***Health Services*****, Vol. 19, No. 4: 415-437.**

Ambulatory visit groups; ambulatory care

This article describes Ambulatory Visit Groups (AVGs) and the process by which they were defined. An approach to the analysis of physician productivity in the ambulatory setting is then demonstrated, with data derived from the National Ambulatory Medical Care Survey [1]. Finally, recommendations for future work are presented to make this approach more effective in designing and managing ambulatory care delivery organizations.

35) **First, Richard J.; Roth, Dee; & Arewa, Darden Bobbie (1988) "Homelessness: Understanding the Dimensions of the Problems for Minorities,"** ***Social Work*****, Vol. 33, No. 2: 120-124.**

Homelessness; minorities

The characteristics and unique service needs of minority homeless persons have received little attention in the literature and in service delivery efforts. The authors review available research on this population, describe the differences between black and white respondents in a large epidemiological study of homeless persons, and explore the implications of those differences for policy development and service delivery.

36) **Flaskerud, Jacquelyn H. & Soldevilla, Elvira Q. (1986) "Pilipino and Vietnamese Clients: Utilizing an Asian Mental Health Center,"** ***Journal of Psychosocial Nursing*****, Vol. 24, No. 8: 32-36.**

Asian-Americans; cross-cultural differences; mental health

Most of the culture mental health nurses have limited knowledge of an ethnic groups' diversity and often refer to them as if they comprised a single group. Asian Americans are a heterogeneous group with many distinguishing characteristics, which include differences in biology and language, conditions and period of immigration, and historical influences such as those resulting from colonialism and war. In order to provide psychiatric nursing care for these populations, mental health nurses must have an understanding of their history, their special problems, and their conceptualizations of health and illness.

37) **Fogel, Peggy (1984) "A Coalition That Works: Medical Indigent Care in Pueblo,"** ***Colorado Medicine*****, October: 160-161.**

Medical care; community planning

In 1982 the existing federally-funded health center lost its federal funding,and the community responded by getting medical care for people who had no health insurance who met federal income guidelines. A group called the Pueblo Community Coalition was formed and aimed to provide low cost health care.

38) **Foxman, Betsy; Valdez, R. Burciaga; Lohr, Kathleen N.; Goldberg, George A.; Newhouse, Joseph P.; & Brook, Robert H. (1987) "The Effect of Cost Sharing on the Use of Antibiotics in Ambulatory Care: Results From a Population-Based Randomized Controlled Trial,"** ***Journal of Chronic Diseases*****, Vol. 40, No. 5: 429-437.**

Ambulatory care; cost sharing; antibiotics

Little is known about how generosity of insurance and population characteristics affect quantity or appropriateness of antibiotic use. Using insurance claims for antibiotics from 5765 non-elderly people who lived in six sites in the United States and were randomly assigned to insurance plans varying by level of cost-sharing, the authors describe how an antibiotic use varies by insurance plan, diagnosis and health status, geographic area and demographic characteristics.

39) **Freeman, Howard E.; Blendon, Robert J.; Aiken, Linda H.; Sudman, Seymour, Mullinix, Connie F.; & Corey, Christopher R. (1987) "Americans Report on Their Access to Health Care,"** ***Health Affairs*****, Vol. 6, No. 1: 6-18.**

Health Care; access

Most Americans believe that health care should be available to all those are sick or injured, regardless of economic or other circumstances. At the same time, most Americans consider the cost of medical care as the most troubling dimension of the provision of this service, and believe that cost constraints should be applied. Where to make such reductions without erasing the gains achieved in access to care over the last several decades, or hurting the least fortunate among us, is the issue. In this essay, the authors report signs of deterioration in access to medical care for the nation's poor, minorities, and uninsured.

40) **Freeman, Stanley J.J.; Formo, Anton; Alampur A. Gopala; & Sommers A. Frank (1979) "Psychiatric Disorder in a Skid-Row Mission Population,"** ***Comprehensive Psychiatry*****, Vol. 20, No. 5: 454-462.**

Homelessness; men; mental health; Skid row

The authors had three questions in mind in undertaking the present study: 1) Who lives on Skid Row in Toronto in the 1970's, and what are the patterns of psychiatric disorder within this population? 2) Is there evidence of a growing proportion of psychotics on Skid Row as a result of the trend to early discharge from mental hospitals? 3) To what degree do the men of skid row receive psychiatric and other medical treatment? Are they a treatable but untreated population? To get at some of these questions, a survey of the sociologic and psychiatric characteristics of a sample of Skid Row men was carried out. The present report deals with the findings immediately related to mental health.

41) **Friedland, Gerald H.; Harris, Carol; Butkus-Small, Catherine; Shine, Daniel; Moll, Bernice; Darrow, William & Klein, Robert S. (1985) "Intravenous Drug Abusers and the Acquired Immunodeficiency Syndrome (AIDS),"** ***Archives Internal Medicine*****, Vol. 145, 1413-1417.**

AIDS; drug use; sexual habits

The authors studied the demographic characteristics, drug use patterns, and sexual habits of intravenous (IV) drug abusers to further define this population at risk for AIDS. Sixteen IV drug abuser patients with AIDS, 24 IV drug abuser patients with AIDS-related complex (ARC), and 14 IV drug abuser controls without evidence of AIDS or ARC were evaluated. The subjects in each group were similar demographically, in drug use practice, and in sexual orientation and experience. Of the AIDS and ARC patients, 34 (88% of 40), including all seven homosexual men, shared needles, as did all drug abusers without AIDS or ARC. 74% of patients , including homosexual men, attended "shooting galleries", where anonymous multi-partner needle-sharing took place. Needle-sharing supports the hypothesis of AIDS transmission by a blood-borne route, can explain the spread of AIDS and the high rate of seropositivity to the putative link between IV drug abusers and male homosexuals, the two largest groups with AIDS.

42) **Froom, Jack (1976) "The Internal Classification of Health Problems for Primary Care,"** ***Medical Care*****, Vol. XIV, No. 5: 450-454.**

Primary care; health problems; classification systems

Health problems of patients seen in the ambulatory settings are different from those encountered in the hospital, and the particular classification of diseases used should reflect these differences. The International Classification of Health Problems in Primary Care (ICHPPC) was designed for use by primary care physicians. It was tested in multiple sites in several countries for one year and has been approved by the World Organization of National Colleges and Academies of Family Medicine-General Practice and other groups concerned with the classification of diseases. The ICHPPC permits classification of the most important part of an ambulatory data see. Data generated by using this classification facilitate outreach to a practice population, construction of diagnostic profiles of health care providers, design of curriculum and health services research.

43) **Fry, John (1983) "Inner City Problems," *Update*, Vol. 27, No. 2: 237-239.**

Inner city; health care

Medical services cannot be left out of the analysis of trends in inner cities. Any remedies for inner city problems must be based on data that relate to medical and social matters. The issues outlined in this article are some trends that have occurred in general practice and in certain social matters in inner cities.

44) **Gelberg, Lillian; Linn, Lawrence; & Leake, Barbara D. (1988) "Mental Health, Alcohol and Drug Use, and Criminal History Among Homeless Adults," *American Journal of Psychiatry*, Vol. 45, 191-196.**

Homelessness; drug use; alcoholism; criminal history; mental health

As part of a community-based survey of 529 homeless adults, the authors analyzed factors associated with their use of mental health services. Homeless persons who had had a previous psychiatric hospitalization were the least likely to sleep in an emergency shelter, had been homeless nearly twice as long as the rest of the sample, had the worst mental health status, used alcohol and drugs the most, and were the most involved in criminal activities. The majority had not made an outpatient mental health visit in 5 years. It is suggested that diverse systems of care are needed for homeless persons.

45) **Gelberg, Lillian and Linn, Lawrence L. (1988) "Social and Physical Health of Homeless Adults Previously Treated for Mental Health Problems," *Hospital and Community Psychiatry*, Vol. 39, No. 5: 510-516.**

Homelessness; adults; mental health; health status

A total of 529 homeless adults in Los Angeles County were surveyed to determine the relationship between their previous use of mental health services and their physical health status, utilization of medical services, personal habits affecting health, experience of injury and victimization, and perceived needs. Homeless adults with a previous psychiatric hospitalization were more likely to have experienced serious physical symptoms during the previous months than those who had used only outpatient mental health services or who had never used mental health services. They reported more reasons for not obtaining needed medical care, were more likely to obtain food from garbage cans, and had the least adequate personal hygiene. However, they did not differ from the other groups on most measure of nutrition, social relations, and financial status. The most frequently expressed needs of the homeless were for the improved social relations, employment, shelter, and money.

46) **Gelberg, Lillian; Linn, Lawrence S. (1989) "Psychological Distress Among Homeless Adults," *Journal of Nervous and Mental Disease*, Vol. 177, No. 5: 291-295.**

Homelessness; adults; mental illness; psychological distress

Recent studies have reported a high prevalence of mental illness among the homeless. As part of a community-based survey of 529 homeless adults, the author developed and tested a model to increase our understanding of the factors related to their psychological distress, it was found that homeless adults were more likely to report psychological distress than the general population (80% vs. 49%). Distress levels were not associated with most demographic or homeless characteristics or general appearance. However, distress was related to unemployment, greater cigarette and alcohol use, worse physical health, fewer social supports, and perceived barriers to obtaining needed medical care. Since mental, physical, and social health are strongly related among homeless adults, alleviating distress among them may be most effectively done by implementing a broad-based health service package coupled with employment programs provided in an accessible service delivery setting.

47) **Gold, Marsha (1984) "The Demand for Hospital Outpatient Services," *Health Services Research*, Vol. 19, No. 3: 384-412.**

Outpatient serivices; medical care

In an investigation of the role played by hospital outpatient services in medical care delivery, objectives were 1) to identify the factors which influence the demand for these services; and 2) to determine the relationship between outpatient service volume and the availability and price of alternative sources of care, particulary office-based physicians and hospital inpatient services. Data were from a merged national data set containing population, socioeconomic, health services, manpower supply, and cost information. Two methods were used to examine demand for hospital outpatient services. The first replicated the earlier work by Davis and Russell using more recent (1978 versus 1969) and more geographically defined (Health Service Area versus state) data. The second extended this work, using the improved availability of data to estimate demand equations, distinguishing between emergency room and other outpatient visits. The results confirmed and extended the findings of earlier efforts. The level of hospital outpatient services appears related both to the availability and the price of other sources of care, as well as to insurance coverage and other factors. These findings have implications for reform of hospital outpatient

reimbursement, for cost containment under Medicaid, and in related areas.

48) **Goldman, Howard H. and Tanube, Carl A. (Jan 1988) "High Users of Outpatient Mental Health Services, II: Implications for Practice and Policy," *American Journal of Psychiatry*, Vol. 145, No. 1: 24-28.**

Outpatient services; utilization; mental health

Four assumptions underlie the stereotyped view of use of outpatient mental health services: 1) all use is alike, 2) any use leads to high use, 3) all high use is discretionary, and 4) insurance encourages excessive use. The authors refute the first three assumptions and suggest that different types of treatment episodes vary in their responsiveness to price. Diagnosis appears to be a poor indicator of inpatient needs; some coverage limits outpatient benefits according to type of treatment. The authors favour a combination of pricing strategies, as well as case management and clinical review for high users, which would not impede initial treatment but would limit excessive use of mental health services.

49) **Goldman, Howard H. and Gattozzi,Antoinette A. (1988) *Murder in the Cathedral Revisited: President Reagan and the Mentally Disabled.***

Mental illness; public policies

A key objective of the Reagan administration when it took office in 1981 was to decrease domestic spending. Intending to offer the new administration " a little bit of a present", employees in the General Accounting Office, an arm of the Congress, identified ineligible Social Security Disability Insurance (SSDI) beneficiaries as a possible source of billions of dollars of savings annually. Subsequently the administration's Office of Management and Budget instructed the Social Security Administration to begin, on an accelerated schedule, aligibility reviews authorized by the Social Security Admendments of 1980. One-fourth of the 130,500 beneficiaries dropped from the rolls during the first full year of the reviews were mentally impaired, although the mentally impaired costituted only one-ninth of SSDI beneficiaries. The reaction by mental health advocacy groups, Congress, and the courts turned "a little bit of a present" into a major problem for the administration, and the various components of government that had consorted on a misguided policy began to make amends. The experience offers useful insights for future policymaking.

50) **Gortmaker, Steven L. (1981) "Medicaid and the Health Care of Children in Poverty and Near Poverty," *Medical Care*, Vol. XIX, No. 6: 567-582.**

Access; utilization of health services; poverty; Medicaid

Recent trends in access to, and utilization of health services by children living in poverty, near poverty, and higher income households in the Flint, Michigan, metropolitan area are examined. During the period under study (1973-1977), there were substantial increases in the percentage of poor children enrolled in Medicaid. By 1977, however, 15 percent of children in poverty in the city of Flint were still not enrolled; in suburban areas, this estimate was 30 percent. Some correlates of non-enrolments are identified. These changes in Medicaid enrollment were accompanied by an attenuation of differences in the utilization of ambulatory medical services among income groups, although children in Medicaid in 1977 were still less likely to have a regular source of care, and less likely to have a pediatrician as a regular physician. Although dental visits were covered by Medicaid beginning in 1975, economic differentials in dental utilization appear to have widened over the period under study. A variety of barriers to the delivery of services under Medicaid in this community are noted, and the generalizability of these findings discussed.

51) **Hagen, Jan L. (July-Aug 1987) "Gender and Homelessness," *Social Work*, Vol. 32, No. 4: 312-316.**

Homelessness; women; men

A homeless population requesting social services from a centralized intake agency for the homeless was studied in a moderately sized community. Particular attention was given to the similarities and differences for homeless women and men. The findings indicate women and men experience homelessness somewhat differently. Women were more likely to become homeless because of eviction and domestic violence, whereas men were more likely to become homeless as a result of unemployment, alcohol abuse, and jail release.

52) **Henderson, Mary Griffin (1986) "Casemix and Determinants of Resource Utilization in Alternate Ambulatory Sites," *Dissertation Abstracts International*, Vol. 46, No. 7: 2017-A.**

Primary care; patient characteristics

A study was undertaken to provide information about the differences in adult primary delivered in hospital outpatient departments and community health centers. Survey instrument used was the National Ambulatory Care Medical Survey (NAMCS), designed to capture info in patient sociodemographic

characteristics, medical problem variables, including principal and secondary diagnoses, provider type, visit status characteristics, and resource utilization.

53) **Herman, Helen; McGorry, Patrick; Bennet, Pamela; van Riel, Raphael & Sing, Bruce (Sept. 1989) "Prevalence of Severe Mental Disorders in Disaffiliated and Homeless People in Inner Melbourne," *American Journal of Psychiatry*, Vol. 146, No. 9: 1179-1184.**

Mental illness; homelessness; inner city

The authors determined the prevalence of mental illness in 382 people representative of the occupants of shelters for the homeless and cheap single-room accommodations in inner-city areas of Melbourne. Clinicians were trained to use a standardized diagnostic instrument, the Structured Clinical Interview for DSM-III-R, to diagnose a range of severe mental disorders, including psychotic, affective, and substance-related diagnoses of current disorders, and over 70% received lifetime diagnoses. There was considerable comorbidity. Many factors are likely to contribute to the concentration of people with mental disorders in such homeless and disaffliated groups.

54) **Hiok-Boon Lin, Elizabeth; Ihle, Loren J.; & Tazuma, Laurie (1985) "Depression Among Vietnamese Refugees in a Primary Care Clinic," *American Journal of Medicine*, Vol. 78, 41-44.**

Vietnamese refugees; health care; cross-cultural differences; depression

Refugees are at a high risk for mental disorders and manifest cultural influences in their health behavior. The Vietnamese Depression Scale was administered to Vietnamese patients at a community clinic to access the underlying prevalence of depression. The rate of accurate diagnosis and the manifestations of depression were also examined. A high prevalence of depression (52 percent) and a high level of underdiagnosis (56 percent) by primary care physicians were found. Ninety-five percent of these patients presented physical symptoms. Compared with patients who had negative depression scores, those who had positive depression scores were more likely to be older and sought care at the clinic frequently. These findings underscore the importance of depression as an urgent health problem among Vietnamese refugees in primary care. Accuracy in diagnosis can be improved by using the Vietnamese Depression Scale and constitutes the first step toward effective treatment.

55) **House, Millie W. and Wilkins, Grace K. (July 1989) "A Forward Movement in Medicine-Ambulatory Care," *Nursing Management*, Vol. 20, No. 7: 88-90.**

Ambulatory care; health services

This article describes the ambulatory care services in Pitt County Memorial Hospital and their expansion of this service. The resulting effects on patient care delivery is also looked at and explores future implications.

56) **Hu, Dale J.; Covell, Ruth M.; Morgan, Jeffrey; Arcia, John (1989) "Health Care Needs for Children of the Recently Homeless," *Journal of Community Health*, Vol. 14, No. 11: 1-8.**

Homelessness; children; health care

Thirty families were surveyed at a shelter for the homeless in San Diego, California concerning the health care status and needs of their children. 56.7% of the families had no regular source of health care and 46.6% were not covered by any form of health care coverage. Children whose families had a regular source of health care were more likely to have reported better health and more frequent check-ups. Also, increased duration of homelessness was predictably correlated with poorer reported health of the children. Though the families sampled were representative of those recently made homeless (i.e. less than six months), needs were identified that would be applicable to all homeless families. The most frequent needs the families expressed for their children were: general nonemergency clinics (76.7%), emergency services (66.7%), and dental services (66.7%). Nutritional and dietary counseling were chosen by 43.3% and only 6.7% of the parents rated social and psychological services as needed.

57) **Hutchison, William J.; Searight, Priscilla; and Stretch, John J. (Nov.-Dec. 1986) "Multidimensional Networking: A Response to the Needs of Homeless Families," *Social Work*, Vol. 31, No. 6: 427-430.**

Homelessness; model programs; family

Homelessness is a growing national problem. The authors draw on models of social networking to present findings from their six-year study of homeless families who received treatment at the Salvation Army Emergency Lodge in St. Louis, Missouri. A four-stage model of treatment is presented and discussed.

58) **Isaac, David (1986) "Shared Antenatal Care: an Alternative," *Australian Family Physician*, Vol. 15, No. 7: 927-931.**

Antenatal care; socioeconomic status

A pilot programme of community-based antenatal care in conjunction with a public maternity hospital is outlined. A target group of women at risk is identified. The benefits to them of share care are evaluated and discussed.

59) **Jencks, Stephen F. and Dobson, Allen (1987) "Refining Case-Mix Adjustment," *New England Journal of Medicine*, Vol. 317, 679-86.**

Case mix adjustments; medical care; Medicare

The authors review case-mix adjustment, which is the process of adjusting for differences in the cases treated in different hospitals so that their costs or outcomes can be compared. They examine the Medicare payment system, which rests on case-mix adjustment and identify areas, including outlier payments, in which payment accuracy might be improved without better measurement of the severity of illness. There is no available measure of severity of illness that would produce a large improvement in the accuracy of Medicare payments if used to supplement of replace the system of diagnosis-related groups. Evidence regarding whether better measurement of severity would substantially change the distribution of payments across hospitals is mixed. Considerable evidence suggests that the intensity of medically appropiate treatment for patients in the same diagnosis-related group varies substantially for reasons other than the severity of illness. Despite great demand for measures of the quality of care, important technical problems must be solved before we can be confident that differences in case-mix-adjusted outcomes reflect differences in the quality of care.

60) **Jones, Robert E. (1983) *Street People and Psychiatry: An Introduction.***

Homelessness; media; mental illness

Homelessness is not a new problem in the United States, but during the current recession there has been an unprecedented increase in the number of people, many of them mentally ill, who live on the streets of American cities. The author traces the history of the homeless mentally ill in the United States; he then discusses the role of media coverage and reports if the scientific literature in alerting the public and the mental health field to the plight of the street people. The impact of deinstitutionalization and the work of advocacy organizations such as the National Coalition for the Homeless and the Philadelphia Committee for the Homeless are also discussed.

61) **Keeler, Emmett B.; Solomon, David H.; Beck, John C.; Mendenhall, Robert C.; & Kane, Robert L. (November 1982) "Effect of Patient Age on Duration of Medical Encounters with Physicians," *Medical Care*, Vol. XX, No. 11: 1101-1108.**

Physician patient encounters; age

The authors analyzed the USC DRME Practice Study data to determine if the characteristics of physician patient encounters change with patient age. The only significant change observed was a decline in encounter time for patients 65 years of age and older compared with those 45 through 64 years of age. This decrease was significant for raw data weighted for the number of physicians of various types and standardized for complexity of case mix in various age groups, also for both nonhospital and hospital encounters and for almost all classes of encounters. Three types of generalists and four types of medical subspecialists were studied; encounter times for all types were, for patients 65 and older, either the same or less than those for patients 45 through 64. The observed phenomenon may reflect a conscious decision on the part of some physicians to allot less time to elderly patients.

62) **Kinzie, J. David (1986) "Mental Health Treatment That Transcends Cultural Barriers," *Hospital and Community Psychiatry*, Vol. 37, No. 11: 1144-1147.**

Asian-Americans; refugees; cross-cultual differences; mental health

The Indochinese psychiatric clinic serves as a link between its patients and area health care and social service providers. It is important that the Indochinese refugee community have easy access to emergency health care services because of the Asian tendency to delay seeking psychiatric treatment until a crisis occurs.

The clinic's success of 90% patients continue in follow-up care, on average clinic patients visit more than twice as often as American patients visit university's psychiatric clinic.Wider range of mental illness is indicative of the growing acceptance of the Indochinese Psychiatric Clinic by the Southeast Asian refugee community. Almost 1/2 of patients suffer from depression. They also complain initially of somatic problems. In evaluation, is a detailed psychosocial and past history. There are five important areas: life in homeland, including education, socioeconomic status, health, family relationships and war-related problems, experiences during escape process, life in refugee camp, adjustments to the U.S., and current problems and worries about the future. The value of medical model has several advantages over the psychotherapeutic model in treating Southeast Asian patients. Asian Americans are believed to underutilize psychiatric treatment because of cultural taboos. But Dr. Kinzie believes that the Indochinese refugees avoid

mental health care for another reason--mental health services in this country are geared to middle-class Americans. The success of the Indochinese clinic provides a service that is sensitive to the unique needs and expectations of Indochinese patients.

63) **Kleinman, Arthur; Eisenberg, Leon; & Good, Byron (1978) "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research,"** ***Annals of Internal Medicine*****, Vol. 88, No. 2: 251-258.**

Health problems; cross-cultural differences

Major health care problems such as patient dissatisfaction, inequity of access to care, and spiraling costs no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may provide an alternative framework for identifying issues that require resolution. A limited set of such concepts is described and illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implememtation of this approach in medical teaching and practice requires more support, both curricular and financial.

64) **Koegel, Paul and Burnam, Audrey (1988) "Alcoholism Among Homeless Adults in the Inner City of Los Angeles,"** ***Archives of General Psychiatry*****, Vol. 45, 1011-1018.**

Homelessness; alcoholism; inner city

The prevalence, course, and severity of alcoholism were examined in a probability sample of homeless adults in Los Angeles' inner city and in a household sample (drawn from two communities in Los Angeles), matched to the demographic characteristics of the homeless sample. Both lifetime and current prevalence of alcoholism (as measured by the National Institute of Mental Health's Diagnostic Interview Schedule) was substantially higher among homeless individuals. Moreover, compared with household alcoholics, homeless alcoholics were characterized by 1) a substantially higher prevalence of other psychiatric disorders, particularly the major mental illnesses; 2) more severe patterns of drinking, which spanned longer periods of time; and 3) more profoundly affected levels of social and vocational functioning. Homeless alcoholics were also more likely to have entered treatment programs and to have engaged in problem behaviors as children and adults. Emphasis was placed on the complicated etiologic relationship between alcoholism and homelessness, and on the need for alcohol rehabilitation services that are sensitive to the unique situations in which homeless alcoholics find themselves.

65) **Koegel, Paul and Burnam, Audrey (1988) "The Prevalence of Specific Psychiatric Disorders Among Homeless Individuals in the Inner City of Los Angeles,"** ***Archives of General Psychiatry*****, Vol. 45, 1085-1092.**

Homelessness; mental illness; Skid Row

Lifetime and current prevalence of Diagnostic Interview Schedule/DSM 111 disorders were determined for a probability sample of homeless adults in the Skid Row area of Los Angeles. Compared with findings from a household sample, prevalence was substantially higher for every disorder assessed. Rates of major mental illnesses were the most disproportionately high. Substance abuse was more highly prevalent among older individuals and Native Americans, while schizophrenia was most highly prevalent among those subjects between 31 and 40 years of age. Rates of both substance abuse and schizophrenia were elevated among individuals who had been homeless many times or for long periods of time. It was estimated that 28% of subjects in this inner-city homeless sample were chronically mental ill, a percentage that was consistent with results of well-designed studies employing nondiagnostic standardized measures of mental illness, but lower than results of studies relying on clinical judgement to assess the prevalence of specific disorders. There is a need for simultaneous attention to the social welfare and mental health needs of homeless mentally ill individuals.

66) **Lamb, Richard H., and Grant, Robert W. (April 1983) "Mentally Ill Women in a County Jail,"** ***Archives of General Psychiatry*****, Vol. 40, 363-368.**

Mental illness; women; criminal history; inmates

The authors studied 101 inmates of a county jail for women who were randomly selected from those referred for psychiatric evaluation. Eighty-six percent had a history of psychiatric hospitalization; 94% had prior arrest records, 50% of these for felonies. More than half met the criteria for involuntary hospitalization. When arrested more than 40% were transients, and only 7% were employed. Seventy percent had histories of serious physical violence, more than 40% had engaged in prostitution, and 84% of those with children had demonstrated an inability to take care of them. Far fewer mentally ill women than men were incarcerated in county jail. As in the authors' study of male inmates, there appeared to have been some "criminalization" of the mentally ill. There is a need for more mandatory aftercare and ongoing involuntary treatment for this population.

67) **Lamb, Richard H. and Grant, Robert W. (Jan 1982) "The Mentally Ill in an Urban County Jail," *Archives of General Psychiatry*, Vol. 39, 17-22.**

Mental illness; criminal history; inmates

One hundred two male inmates of a county jail, randomly selected from those referred for psychiatric evaluation, were studied. Ninety percent had had psychiatric hospitalization; 92% had prior arrest records, 75% for felonies. Four fifths exhibited severe, overt psychopathology. More than three fourths met the criteria for involuntary hospitalization. When arrested, more than one third were transients and only 12% were employed. Thus, this population is characterized by extensive experience with both the criminal justice and mental health systems, severe acute and chronic mental illness, and poor functioning. More than half were currently charged with felonies and 39% with crimes of violence. The authors also attempted to determine why inmates had been arrested rather than hospitalized and whether there has been "criminalization" of the mentally ill. There appears to be a need for more emphasis on ongoing involuntary treatment for this population.

68) **Leslie, Adams Linda; & Swider, Susan M. (March 1986) "Changing Factors and Changing Needs in Women's Health Care," *Nursing Clinics of North America*, Vol. 21, No. 1: 111-123.**

Health care; women

During the last few decades, the roles of women in society have undergone tremendous changes. These changes have occurred in the occupational realm and in the home and have far-reaching consequences for women's health. In addition, improvements and modifications in health care technology and delivery have affected the general health status of women. These changes are reflected in the health, social, and economic status indicators available from a variety of sources.

69) **Linn, Lawrence S. & Gelberg, Lillian (1989) "Priority of Basic Needs Among Homeless Adults," *Social Psychiatry and Psychiatric Epidemiology*, Vol. 24, 23-29.**

Basic needs; homelessness

Good health was the need most frequently chosen by the samples of homeless adults. More than half always chose good health above everything else. The second highest priority of need was a steady source of money, followed by a permanent job. A permanent home was viewed as fourth most important and regular meals were least likely to have been chosen by the sample. There appears to be subgroups which differ socio-demographically and who have different lifestyles, health habits, perceptions of health, and clearly different priorities of need.

70) **Lion, Joanna (1987) "Ambulatory Visit Groups: Implications for Hospital Outpatient Departments," *J Ambulatory Care Manage*, Vol. 10, No. 1: 6-69.**

Ambulatory care; classification system

This article provides a discussion and evaluation of a clinically meaningful classification system that could distinguish among types of patients for the resources they consume that is increasingly important for hospital management and financing. This article has provided the results of using a newly developed case-mix classification system on cinic ambulatory care data. Many problems remain. The possibility exists that third party payers could be motivated to use this system for productivity measures or reimbursement to hospital clinics within the next few years. In the interim, the AVGS presented here might benefit from considerable hospital clinic output particularly in the areas of testing case-mix comparisons, refining the dependent variable, and establishing a weighting scheme.

71) **Lion, Joanna (1981) "Case-Mix Differences Among Ambulatory Patients Seen by Internists in Various Settings," *Health Services Research*, Vol. 16, No. 4: 407-413.**

Case-mix differences; health care; ambulatory settings; hospital outpatient departments

Attempts to enlarge upon Marsha Gold's findings using results of a study on the cost of ambulatory care currently being conducted by the Heller School at Brandeis University. This article examines physician practices across the whole range of practice settings, both fee-for-service and salaried, as well as along a continuum from solo practice to teaching hospital-based. Three measures of the difficulty of the case mix as well as actual minutes spent with the patient are used in addition to tests.

72) **Lion, Joanna and LaVor, Judith Williams (1983) "Medical and Socioeconomic Case Mix in Outpatient Departments," *Ambulatory Care:Problems of Cost and Access*, edited by Stuart H. Altman, Joanna Lion, & Judith LaVor. (Lexington, Mass: Lexington Books), 161-178.**

Case-mix differences; ambulatory care; socioeconomic status; hospital outpatient departments

The author examines the available evidence for medical-case-mix differences between hospital OPDs and private practices using a large-scale, nationwide data set developed in the late 1970's. It then looks at data from a recent survey conducted in three Boston teaching hospital OPDs, first at medical case-mix within these OPDs and then turning to findings about socioeconomic case-mix in these settings. Finally, the authors look at the use of OPD resources by patients with and without social problems.

73) **Lion, Joanna; Malbon, Alan; Henderson, Mary G; and Friedman, Robert H. (Summer 1985) "A Comparison of Hospital Outpatient Departments and Private Practice," *Health Care Financing Review*, Vol. 6, No. 4: 69-81.**

Ambulatory care; case-mix differences; private practice; hospital outpatient departments

This article addresses cost differences between primary care physicians in private practice and hospital outpatient departments (OPD's). The analysis utilizes ambulatory visit groups (AVG's), the outpatient equivalent of diagnosis-related groups (DRG's), to adjust for case mix. Major findings are that OPD's have higher per visit costs than physicians's private offices; internists are more expensive than general practitioners regardless of site; and ancillary service costs are actually slightly higher in private practice. Any prospective payment system for ambulatory care must consider these costs differences.

74) **Lion, Joanna (August 1988) "Case Mix of Visits to Hospital Clinics in a Large Urban Area," *Journal of Ambulatory Care Management*, 23-35.**

Ambulatory care; case-mix differences

The authors presents descriptive results from a diagnostic case-mix analysis of a representative sample of visits to hospital clinics and emergency departments in a large urban area. Results reported here confirm the more common belief that the case mix seen in emergency department differs substantially from that of other hospital-based clinics even in a large city where emergency departments are known to provide a large amount of primary care. The New York city clinic population is representative of the national, hospital-based ambulatory case system in several ways. Population includes twice the fraction of minorities as national population, and are substantially poorer. NYC hospitals also provide more ambulatory care as a fraction of hospital activity than do hospitals nationwide. Data was obtained from Patient Origin Information System (POIS), a database for general hospital ambulatory care. The most important findings from a policy point of view is that emergency departments do not appear to be delivering a substantial amount of primary care in this large urban area when general diagnostic categories are examined, but are shown to be delivering the illness component of primary care when specific diagnoses are examined.

75) **Lion, Joanna & Altman, Stuart (September 1982) "Case-Mix Differences Between Hospital Outpatient Departments and Private Practice," *Health Care Financing Review*, Vol. 4, No. 1: 89-98.**

Case-mix differences; outpatient services; private practice

This article investigates the commonly held belief that patients seen in hospital outpatient departments (OPDs) are sicker than those seen in private practice. This assumed case-mix difference is said to be one of the reasons OPD per-visit costs are higher than costs in private practice. It is generally agreed that stand-by capacity and other costs peculiar to the OPD, such as social workers, overhead attributed from the inpatient portion of the hospital, and research and education costs, play a part in the OPD's greatly increased cost structure as well.

76) **Liberman, Aaron & Fougerousse, Jack G. (April 1970) *Community-based Outpatient Clinic and Transportation Service.***

Community planning; medical care; access

This article deals with the issue of how effective medical care can be brought to inner-city area residents who are traditionally suspicious of any hospital connection. An innovative program called "Operation Outreach" was established in Indianapolis designed to bring health facilities to those who would not come to the hospital, and provide free bus transportation to make hospital visits easier.

77) **Lindsey, Ada M. (1989) "Health Care for the Homeless," *Nursing Outlook*, Vol. 37, No. 2: 78-81.**

Homelessness; health care

As the number of homeless in our towns and cities grow, the need for a coordinated effort to address the problem becomes increasingly important. To comprehend the complexities involved, it is necessary to consider why homelessness has emerged as a sociopolitical, economic, public health phenomenon; the magnitude of the problem; and the characteristics of this current homeless population.

78) **Lipton, Frank R. (1983) *Down and Out in the City: The Homeless Mentally Ill.***

Homelessness; mental illness; patient characteristics

The plight of the homeless in New York City and other urban areas has become the focus of increasing attention. In an effort to clarify and understand the problems of the homeless, the authors studied the demographic characteristics, psychiatric diagnoses, histories, and dispositions of 100 homeless patients treated at Bellevue Psychiatric Hospital's emergency service. The most striking finding was that 96.6 percent of the sample have had a previous psychiatric hospitalization. Seventy-two percent of these homeless patients were diagnosed as suffering from schizophrenia; the second most common diagnosis was personality disorders, which accounted for 13.3 percent of the sample. The authors discuss other demographic findings of their study and explore the roots of the problem of homelessness, review the psychiatric literature on the subject, and delineate some of the unique treatment needs of this population.

79) **Lucey, Don and Parker, Sheila (1987) "The Open Door Medical Clinic: A Community Response to the Medically Indigent," *North Carolina Medical Journal*, Vol. 48, No. 9: 457-458.**

Free clinic; community planning; health care

Many individuals in Wake County had no access to a health care system because of the lack of medical insurance. This need led to the development of a free health clinic that would provide medical and dental care to those who could not pay. Details about physicians' hours of operation, pharmacy/laboratory supplies are reviewed by the authors.

80) **Maayan, Shlomo; Wormser, Gary P.; Hewlett, Dial; Miller, Steven N.; Duncanson, Frederick, P.; Rodriguez, Angela; Perla, Elliot N.; Koppel, Barbara & Rieber, Egmond E. (September 1985) "Acquired Immunideficiency Syndrome (AIDS) in an Economically Disadvantged Population," *Archives of Internal Medicine*, Vol. 145, 1607-1612.**

AIDS; poverty

Forty patients with acquired immunodeficiency syndrome (AIDS), 70% of whom were intravenous drug users (IVDAs), were seen over a 20-month period (July 1,1982 through Feb.28, 1983). Most of the patients came from two inner-city sections of New York City and from nearby correctional facilities. Eighty-five percent of the patients were black or Hispanic, only 15% were white. Unique features of AIDS in this mostly heterosexual population were the high incidence of opportunistic infections (90% of the patients), the low incidence of Kaposi's sarcoma (10%), and the high mortality rate (34% died during initial hospitalization, 74% after one year of follow-up). Tuberculosis occurred in 10% of cases, preceding other opportunistic infections by four to 24 months. We found that AIDS was a common disease among inpatient IVDAs, and in one of the participating hospitals, its incidence was similar to that of infective endocarditis. Acquired immunodeficiency syndrome should be considered as the underlying illness in all IVDAs with oral thrust, shortness of breath, pneumonia, or extrapulmonary tuberculosis.

81) **MacIntyre, D. (1979) "Medical Care for the Homeless-Some Experience in Glasgow," *Scottish Medical Journal*, Vol. 24, 240-43.**

Homelessness; medical care

The experience of running a medical clinic using voluntary help for the homeless is described. As a group they have limited access to normal medical channels despite high morbidity. In particular psychiatric illness, most frequently related to alcohol abuse, infestation, respiratory disease, and problems were encountered. The effects of such special arrangements for the homeless are assessed.

82) **Main, Thomas J. (Summer 1983) "The Homeless of New York," *The Public Interest*, No. 7: 23-28.**

Homelessness; emergency shelter

This article deals primarily with New York City's shelter system and the lodging of homeless people. From a study released by the Bureau of Management Systems, Planning, Research, and Evaluation of the City Human Resources Administration, information is collected by categorizing shelter clients. The problems of homelessness turned out to be at least three very different problems in New York City. 1) Problem with former mental patients and others suffering from mental illness. 2) Alcohol and drug problems. 3) Difficult care and "economic only" cases. There are people who are suffering from no disability who are simply locked in a network of circumstances that make the shelters look attractive to them. Within this subgroup, the article examines guidelines for shelter policy, separate policies for these sub-populations, and how to prevent dependency.

83) **Marwick, Charles (June 1985), "The "Sizable" Homeless Population: A Growing Challenge for Medicine," *Journal of American Medical Association*, Vol. 253, No. 22: 3217-3225.**

Homelessness; medical care

Medical disorders of the homeless as well as other medical symptoms are examined in this article. Factors contributing to the increasing numbers of the homeless are also discussed.

Medical practitioners are dealing with a complex panoply of illness in a lot of these people. The American Psychiatric Association drew up a series of recommendations to aid the homeless in policy. The principal ones are summarized as follows: 1) A recognition of the need to provide community care. 2) Development of a system of responsibility 3) Develop a new concept of asylum.

84) **Mendenhall, Robert C.; Lloyd, John S.; Repicky, Paul A.; Monson, Joanne R.; Girard, Roger A.; & Abrahamson, Stephen (September 1978) "A National Study of Medical and Surgical Specialties: II. Description of the Survey Instrument," *Journal of American Medical Association*, Vol. 240, 1160-1168.**

Physician-patient encounters; log-diary

The survey instrument used in the national study of physician activities conducted by the University of Southern California, Division of Research in Medical Education, is a log-diary in which physicians kept a record of their actual professional activities. The log-diary focused on use of physician time and patient encounters and employed numerical coding of activities and patient encounters in a highly structured format. Compared with instruments used in similar studies, this log-diary appears to gather a greater breadth and depth of information about physician practice patterns.

85) **Medenhall, Robert C.; Girard, Roger A.; & Abrahamson, Stephen (September 1978) "A National Study of Medical And Surgical Specialties: I. Background, Purpose, and Methodology," *Journal of American Medical Association*, Vol. 240, 848-852.**

Specialists; primary care

The University of Southern California is conducting a national survey of physicians involving the collection and analysis of detailed data on the activities and practice characteristics of generalists, medical specialists, and surgical specialists of different types. This is the first of a series of reports on the survey and provides an overview of the survey's background, purposes, and general research methods. Basic features of the research methods include the development of a survey instrument capable of obtaining different types of practice data from physicians in most specialties and practice arrangements, the sampling of the physician population to ensure that sufficient data are obtained from physicians in most specialties and practice arrangements, and the creation and application of a scheme for classifying patient-care services provided by physicians along dimensions related to primary care.

86) **Mowbray, Carol T.;Johnson, Sue V.; & Solarz, Andrea (August 1987) "Homelessness in a State Hospital Population," *Hospital and Community Psychiatry*, Vol. 38, No. 8.**

Homelessness; patient characteristics; hospital population; basic needs

The purpose of this study is to determine the extent to which the homeless are represented in a state hospital population and to identify the characteristics and service needs of this subgroup. Little information exists on the reciprocal connection between homelessness and psychiatric institutionalization, although there is evidence that homelessness tends to exacerbate psychiatric symptomatology and contribute to mental health problems.

87) **Moxley, John H. and Roeder, Penelope C. "New Opportunities for Out-of-Hospital Health Services," New England Journal of Medicine, Vol. 310, No. 3: 193-197.**

Ambulatory care; home health care

This article discusses a few types of either extant now or in development, the two types in two broad categories: Ambulatory care and home health care. Next, a discussion about some of the demographic, economic, and sociological trends that have contributed to the recent spread of these services are looked at. There are several types of ambulatory-care centers in existence, free-standing ambulatory-surgery center (usually dominated by physicians and formed a self-contained and largely anti-hospital network) Urgent-care centers; Occupational medical clinics; Pure-form primary-care centers. There is an increasing pattern for ambulatory care moving from hospital settings to independent freestanding facilities the authors have reviewed.

88) **Newacheck, Paul W. and Halfon, Neal (1986) "Access to Ambulatory Care Services for Economically Disadvantaged Children," *Pediatrics*, Vol. 78, No. 5: 813-819.**

Ambulatory care; access; poverty; health services; children

Using data from the 1981 Child Health Supplement to the National Health Interview Survey, the authors examined the differences in access to ambulatory services for children of different family incomes. The results indicate that much progress has been made in equalizing access since the War on Poverty was initiated in the mid-1960s. Poor children with superior health status now generally see physicians at the same rates as children in similiar health but from higher income families. However, children with substantial health problems from low-income families continue to lag behind their higher

income counterparts in similiar health. Medicaid was shown to substantially improve access to ambulatory services for economically disadvantaged children in poor health, but less than half of these children are covered by Medicaid. Recent changes in federal and state politics concerning Medicaid are discussed as well as policy options for addressing the needs of children afflicted by both poverty and ill health.

89) **Newacheck, Paul W. (1988) "Access to Ambulatory Care for Poor Persons," *Health Services Research*, Vol. 23, No. 3: 401-419.**

Public policy; ambulatory care; utilization of services; poverty

Studies conducted during the 1970s have reported conflicting results concerning whether differences in use of physician services between poor and nonpoor persons have been eliminated. Using a sample of 92,737 persons from the 1982 National Health Interview Survey and a refined analytic method, this study reexamines utilization of ambulatory care services by persons above and below the poverty level. Before adjusting for health status, no differences were apparent in rates of physician contacts for persons above and below the poverty level. After adjusting for health status, perons below the poverty level were shown to have significantly fewer physician contacts than persons above poverty. Multivariate analysis revealed that Medicaid coverage can effectively counter the depressing effects of poverty on use of physician services. However, only 34 percent of the noninstitutionalized population below poverty level had Medicaid coverage in 1982. Public policy implications concerning Medicaid eligibility are discussed.

90) **Newacheck, Paul W. and Starfield, Barbara (1988) "Morbidity and Use of Ambulatory Care Services among Poor and Nonpoor Children," *American Journal of Public Health*, Vol. 78, 927-933.**

Children; socio-economic status; ambulatory care

Using data from the Child Health Supplement to the 1981 National Health Interview Survey, illness and use of physician services are compared for children under 18 years old in three family income groups. The results indicate that although annual prevalence of many health problems does not differ greatly by income level, disability as measured by bed days is greater among low income children. A substantial minority of children from all socioeconomic levels are afflicted by multiple health problems. The impact of multiple conditions, as measured by days spent ill in bed, appears much greater for children from low income families. Use of physician services was found to be similar for children of all socioeconomic levels when no significant health problems were present, but low income children with health problems used fewer physician visits on an adusted basis than their higher income counterparts.

91) **Nighswander, Thomas S. (1984) "High Utilizers of Ambulatory Care Services: 6-Year Followup at Alaska Native Medical Center," *Public Health Reports*, Vol. 99, No. 4: 400-404.**

Utilization of health services; ambulatory care

In a retrospective study, 100 randomly selected, high utilizers of ambulatory care services in 1972 were followed for a 6-year period, 1973-1978. The 22 men and 78 women had visited the Alaska Native Medical Center in Anchorage 15 or more times in 1972. Each patient was matched by age and sex with a control patient who had made three or fewer visits. There were predominantly more women than men in all age groups in the high utilizer group and in all but one age group in the general clinic poulation. High utilizer men as a group were older than high utilizer women. In the followup period, the men in the high utilizer group had three times the number of hospitalizations as the controls, and women had two times the number. At the end of the followup period, 1 of every 4 men in the high utilizer group had died, and 1 of every 10 women had died. One-half of these deaths were associated with alcohol. Several approaches to high utilizer patients are useful. A well-organized medical record, with a complete problem list and index, is imperative. Just as helpful is only having one several health care providers consistently see the patient at each encounter. Until there is more study of these complex issues, high utilizers must be recognized as a subgroup of patients at a high risk for hospitalization and early death.

92) **Olin, Jack S. (1966) *"Skid Row" Syndrome: A Medical Profile of the Chronic Drunkenness Offender.***

Inmates; alcoholism; Skid Row

From Skid Row, 227 chronic "drunks", inmates of the Toronto Jail, were studied to determine the physical features and illnesses of this group. Complete physical examinations, liver function tests, routine hematology, urinalysis, chest radiographs were carried out and previous hospital records were obtained for each man. The data were analyzed by IBM computer and reported in terms of body systems. Items that occurred in sufficient frequency were separated out and listed to compile a "Skid Row" syndrome. The men averaged 45 years of age, had been drinking heavily for 20 years and had four drunken convictions a year. Tuberculosis was found in 8.8%. Epilepsy was confirmed in 8%, Cirrhosis of the liver was definite in 3% of the group, 75% were under the Canadian average weight, and 25% had significant body deformities. It was estimated that, if

necessary therapy was carried out, 90% of the men would be able to perform useful labour.

93) **Parrinello, Kathleen; Brenner, Phyllis C.; & Vallone, Barbara (1988) "Refining And Testing A Nursing Patient Classification Instrument in Ambulatory Care,"** ***Nursing Administration Quarterly*****, Vol. 13, No. 1: 54-65.**

Ambulatory care; classification system

As ambulatory care services expand, it becomes necessary to manage them effectively. Effective management of human and fiscal resources depends on a clear understanding of the nature and type of services provided. To date, very little has been done to identify, measure, or classify nursing needs of patients in ambulatory care settings. However, with the explosion in volume and diversity of ambulatory care services provided, it is essential for nurse managers to gain a better understanding of nursing care requirements and the allocation of resources in ambulatory care settings. Therefore a study was designed to refine and test a nursing patient classification instrument for ambulatory care at the University of Rochester Stron Memorial Hospital (URSMH).

94) **Patel, Kanti R. (April 1986) "Diagnostic Traps in the Care of Immigrant Patients,"** ***Postgraduate Centres Update*****, 563-570.**

Cross-cultural differences; health care

The author describes the physical and cultural factors that may influence the diagnosis and treatment of immigrant patients. He also emphasizes the importance of doctor-patient rapport in understanding differences in moral and religious beliefs, and their effect on treatment.

95) **Patrick, Donald L.; Stein, Jane; Porta, Miquel; Porter, Carol Q.; & Ricketts, Thomas C. (1988) "Poverty, Health Services, and Health Status in Rural America,"** ***The Milbank Quarterly*****, Vol. 66, No. 1: 105-136.**

Poverty; health services; health status

Access to health services for everyone has been a major policy goal in the social and political environment of the U.S. Concentration of health policy on availability and access is based on the assumption that decreased access to medical care leads to decreased health status, particularly for low income groups. This assumed relation between poverty and health status can be illustrated as follow:

Health Care Access to
Poverty---->needs------>services---->Health Status

In this simple model, poverty is viewed as a major determinant of the need for health care which, in turn, requires increased access to health services. Decreased access and a low level of health service use are, then, viewed as major reasons for the poor health status outcomes observed among persons below the poverty level. This article addresses the link between poverty and health status in rural communities with subsidized health care, presents a more comprehensive model of the relationship, and outlines changes in policy, practice, and the evaluation of progress in solving problems of inequity.

96) **Powell, P.V. (1988) "Qualitative Assessment in the Evaluation of the Edinburgh Primary Health Care Scheme for Single Homeless Hostel Dwellers,"** ***Community Medicine*****, Vol. 10, No. 3: 185-196.**

Homelessness; hostel; primary care

The Edinburgh Primary Health Care Scheme for Single Homeless Hostel Dwellers was organized in 1977, as a National Health Service provision through which Lothian Health Board could provide special services for the single homeless. Local general practitioners were appointed as "house doctors" to the hostels for the single homeless in Edinburgh, in order to take services to this population. Evaluation of the scheme, to include both quantitative and qualitative analysis, was requested by the Board in 1985, and this paper details the latter. The views of providers, recipients, and other interested parties on the acceptability of the scheme, were sought through interviews and the results are presented. Contrary to findings in other parts of the country there was little evidence of the single homeless having difficulties in gaining access to primary health care services in Edinburgh, or of demand for a change in the service from them. The development of a primary health care team for the single homeless working from a central surgery, however, had proved more acceptable to the providers and the recipients than the original "house doctor" service. Alternatives for primary health care provision for this population are considered in the light of the survey findings, and the need for adequate data collection, service monitoring and evaluation are identified.

97) **Powell, P.V. (September 1987) "The Use of an Accident and Emergency Department by the Single Homeless,"** ***Health Bulletin*****, Vol. 45, No. 5: 255-263.**

Emergency centers; homelessness; hostel

The use of Accident and Emergency (A/E) services by the single homeless as a first point of contact with the health service, and as an alternative to primary care, has been the subject of debate. Investigation of the use of such services in

Edinburgh, where a special primary health care scheme for single homeless hostel dwellers exists, was undertaken. The single homeless were found to make more use of A/E services than the general population, and their consultations were significantly less appropriate. However, the hostel dwellers were also found to use the A/E services significantly less inappropriately than the single homeless from outwith hostels, for whom no special primary care scheme exists. The problems of accurately quantifying this are discussed.

98) **Quesada, Gustava M. (1977) "Sociocultural Barriers to Medical Care Among Mexican Americans in Texas: A Summary Report of Research Conducted by the Southwest Medical Sociology Ad Hoc Committee," *Medical Care*, Vol. XV, No. 5 (Supplement): 93-101.**

Medical care; Mexican Americans; cross-cultural differences

Commitee members individually, or in two-person groups, studied a number of factors concerning Mexican-American medical care in Texas such as 1) mortality, morbidity, and other health status indicators, 2) health manpower and educational needs, 3) political factors impeding economical health care, 4) alienation, familism and their relationship to utilization of the health services, 5) language and communication barriers, and 6) folk medicine. Findings include documentation that structural alienation of Mexican-Americans from Anglo-American middle-class society is carried over into their relation with and utilization of the health care delivery system; that their emphasis on familism works alternatively to encourage and discourage their seeking access to health care, that language differences serve to perpetuate certain cultural differences that are inimical to health care delivery; and that curanderismo can be seen as complementing other types of health care. The report concludes with a number of recommendations for accomplishing cultural integration that will lead to better care for this segment of the health population.

99) **Reiger, Darrel A.;Shapiro, Sam; Lessler, Larry G.; & Taube, Carl A. (Sept.-Oct. 1984) *Public Health Reports*, Vol. 99, No. 5: 483-489.**

Health services; mental health; alcholism; drug use

Data from the NIMH Epidmiologic Catchment Area (ECA) Study in Baltimore, Md., are used to illustrate the association between alcohol, drug abuse, and mental disorder diagnoses with health service use. A probability sample of 3,481 adult (age 18 and over) residents of a geographically defined Baltimore City population of 175,000 was found to have a 23.4 per 100 population, 6-month prvalence of 13 specific alcohol, drug, and mental disorders. Of this population, 7.1 percent sought outpatient mental health treatment from both general physicians and mental health specialists in a 6-month period. The presence of a mental disorder diagnosis increased the average number of visits to all health providers from 1.91 to 4.06 during the same 6-month period.

These data demonstrate the necessity of having additional patient assessment measures with a diagnosis to predict probable service use. However, even in the most comprehensive multi-dimensional model, more research is required to explore the phenomena of presumed unmet need-the 45 percent of those with a diagnosis, disability, and high symptoms who do not use services.

100) **Reuler, James B. (August 1989) "Health Care for the Homeless in a National Health Program," *American Journal of Psychiatric Health*, Vol. 79, No. 8: 1033-1035.**

Health care; homelessness

To assess the impact of adoption of a national health program on homeless care in the United States, care for this group in Britain's National Health Service (NHS) was evaluated. Although hospital and medication charges are eliminated, primary care for the homeless lacks central government directive, suffers from overlap of statutory agenciesa and mechanistic biases, is disproportionately delivered in emergency rooms, and has relied on advocacy by the non-profit sector. Disadvantages of this void in NHS provision are marginalization of the homeless and continuation of a two-class care system. Removal of financial barriers to care by enactment of a national health program in the US would not solve all issues related to delivery of quality care for the homeless unless its structure addressed the special needs of disenfranchised groups.

101) **Robertson, Majorie J. (Fall 1986) "Mental Disorder Among Homeless Persons in the United States: An Overview of Recent Empirical Literature," *Administration in Mental Health*, Vol. 14, No. 1: 14-27.**

Homelessness; mental health

The author has reviewed literature on the homeless, and reports that there is higher rates of psychiatric disorder, psychological distress, and previous psychiatric hospitalization compared to the general population. However, unstandardized methodology and lack of consistent findings across studies prohibit reliable estimates of mental disorder among the homeless.

102) **Robertson, Majorie J. and Cousineau, Micheal R. (1986)" *Health Status and Access to Health Services Among the Urban Homeless*", Administration in Mental Health, Vol.16, No.1:25-30.**

Homelessness; health care

Self-reported health status and access to care were reported for 238 homeless adults in Los Angeles. One-third reported their health as fair or poor; women reported more health problems than men. Half (53 per cent) of the sample reported no regular source of care, and most (81 per cent) were without health insurance. Lack of financial resources and health insurance were reported as important barriers to care.

103) **Rogers, John & Curtis, Peter (1980) "The Concept and Measurement of Continuity in Primary Care," *American Journal of Psychiatric Health*, Vol. 70, No. 2:122-127.**

Primary care; ongoing care;

Continuity of care, a stated fundamental principle of family medicine, is reviewed in terms of its philosophy and definitions. A model of continuity in primary medical practice is proposed, consisting of five elements: the provider, consumer, encounter type, knowledge base, and environment of continuity. The elements are measurable, some more easily than others. There is a need to define and operationalize the model more accurately in order to evaluate continuity in primary care medicine.

104) **Rogerson,Charles L.; Stimson, David H.; Simborg, Donald W.; & Charles, Gerald (1985) "Classification of Ambulatory Care Using Patient-Based Time-Oriented Indexes," *Medical Care*, Vol. 23, No. 6: 780-788.**

Ambulatory care; classification system

This paper presents a new approach to the classification of ambulatory care into isoresource consumption groups. In contrast to classification schemes based on visits, this case-mix approach creates an index based on resources used by diagnostic categories by a patient during a year. An application of this method to a primary care, group practice data base produced resource consumption groups with coefficients of variation in an acceptable range compared with the coefficients of variation of the diagnosis-related groups used to classify inpatient care.

105) **Roos, Noralou P. (1988) "What is the Potential for Moving Adult Surgery to the Ambulatory Setting?" *Canadian Medical Association Journal*, Vol. 138, 809-816.**

Outpatient services; case-mix differences

Data from the Manitoba health insurance program were used to analyse the patterns of outpatient surgery in patients aged 20 years or older in the eight largest hospitals in the province (all with at least 125 beds) in 1983-84. With the exception of tooth extraction, only procedures that were not done more than 86% of the time as inpatient or outpatient procedures were considered. Large differences between the hospitals and between physicians within each hospital were found in the rates of outpatient surgery, even after adjustment for patient characteristics and differences in case mix. If the standard of the hospital with the highest rate of outpatient surgery were followed by the seven other hospitals, up to 17.5 inpatient beds could be closed or freed. However, the potential savings from substituting outpatient for inpatient procedures must be realistically appraised. The appropiate place for monitoring the use of inpatient and outpatient surgery may be the individual hospital, particularly those with high occupancy rates and a large demand for inpatient beds.

106) **Ropers, Richard H. & Boyer, Richard (1987) "Perceived Health Status Among the New Urban Homeless," *Social Science Medicine*, Vol. 24, No. 8: 669-678.**

Homelessness; health status

Homelessness may be the leading social problem in the United States in the mid 1980s. While there may be anywhere from 250,000 to three million homeless persons, few empirically base published studies are available concerning the correlates of mental and physical health status among the homeless. Los Angeles, where the present study was conducted, has been designated by the U.S. Department of Housing and Urban Development to have one of the largest homeless populations (34,000-50,000) in the County, California. The homeless were found to be younger, better educated and disproportionately non-white compared to the profiles of the skidrow homeless of the past decades. Nearly half the men were veterans of military services, including 30% who were veterans of the Vietnam War. Respiratory infections and hypertension were the most prevalent health problems. The data suggest that a large segment of the homeless persons were depressed, 15.6% reported lifetime prevalence of hospitalizaton for emotional or nervous problems, and 12.6% reported hospitalization for substance abuse disorders. Multiple regression was utilized to test the validity of a perceived health status index as measured among the homeless and the severity of an acute condition, the duration of depressed mood, and the alcoholism symptomatology. Length of unemployment, education, gender, and number of nights spent in a shelter were the best indicators of poor health in this

population. Evidence from this study, as well as others, suggest that efforts should be made to avoid using the term homeless metaphorically. The causes of homelessness are multiple and complex and the resulting subgroups among the homeless population have different problems which require a variety of strategies to meet their needs.

107) **Rossi, Peter H. & Wright, James D. (Spring 1987) "The Determinants of Homelessness,"** ***Health Affairs*****, 19-32.**

Homelessness; poverty

In this essay, the authors employ a new approach to the study of homelessness. They conducted their study in Chicago, and describe homelessness as a manifestation of extreme poverty that occurs among disabled and isolated people. They see the number of homeless individuals as reflections of limited availability of low-priced housing for single persons, the limited coverage and modest size of income transfers, and the small number of low-skill jobs available in local markets.

108) **Rossi, Peter H.; Wright, James D.; Fisher, Gene A.; & Willis, Georgianna (1987) "The Urban Homeless: Estimation Composition and Size,"** ***Science*****, Vol. 235, 1336-1340.**

Homelessness; povery

Although homelessness has been recognized as a serious and growing urban social problem, scientifically acceptable methods for estimating the composition and size of the homeless population have been lacking. A new research approach to estimating the size and composition of undomiciled urban population is presented, and its utility is illustrated through a description of the literal homeless of Chicago. The homeless in the Chicago sample are unaffiliated persons living in extreme poverty, with high levels of physical and mental disability. Homelessness is interpreted as a manifestation of extreme poverty among persons without families in housing markets with declining stocks of inexpensive dwelling units suitable for single persons.

109) **Roth, Dee & Bean, Gerald J. (1986) "New Perspectives on Homelessness: Findings From a Statewide Epidemiological Study,"** ***Hospital and Community Psychiatry*****, Vol. 37, No. 7: 712-719.**

Homelessness; patient characteristics; mental health

The social problem of homelessness is of increasing concern to mental health professionals. In a large-scale study of homelessness in Ohio, data were collected in face-to-face interviews with 979 homeless people in 19n counties. The median length of homelessness was 60 days. Almost half the respondents cited economic factors, such as unemployment or problems paying rent, as the major reason for their homelessness. Thirty percent had been hospitalized at least once for mental health reasons, and 31 percent showed symptoms serious enough to require mental health services. Findings are also presented in relation to a typology of the homeless-street people-and urban and rural respondents are compared. These and other findings support the principal conclusions that homelessness is clearly a multidimensional problem and that service strategies must reflect the multiple needs and varying characteristics of homeless people.

110) **Roth, Julius A. (1969) "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of the Hospital Emergency Service,"** ***American Journal of Sociology*****, Vol. 77, No. 5: 839-856.**

Emergency centers; patient characteristics; health care

One important aspect of the control of behavior of patients and visitors on a hospital emergency service is the moral evaluation of the clients made by the staff. Such evaluation arises from the application of concepts of social worth common in the larger society and from staff concepts of appropiate work role. The process, however, is not a simple cause-effect matter, but the product of a reciprocal relationship between the attributes of the client and the categories of the staff. Emergency-department staff, like other service occupations, attempt to establish mechanisms of control over inappropriate demands for service.

111) **Rudd, Peter and Carrier, Adele C. (1978) "Patients of Internists in Hospital Outpatient Departments and in Private Practice,"** ***Canadian Medical Association Journal*****, Vol. 119, No. 8: 891-895.**

Medical care; patient characteristics; private practice; outpatient services

To test the contention that patients in outpatients departments and private practices differ, variables were accessed that might affect both the process and the outcome of medical care. Two groups of 60 patients consulting nine Montreal internists who worked in both private practice and in an outpatient department of a university teaching hospital were surveyed. The internists served as their own controls. The two groups of patients were compared for 57 demographic, socioeconomic, access, utilization, attitudinal and current medical status variables. Financial factors were mimimized by the existence of universal health insurance. The outpatient group was found to be older, less fluent in English, less likely to be employed, less educated,

less wealthy, more dependent on public transportation, more disabled, more likely to use ambulatory services,more anxious about health, and more skeptical about physicians, yet more dependent on them than the private practice group. The outpatient group tended to have more active, significant medical conditions and to receive more prescriptions for medication than the private practice group, in contrast to the national patterns in the practice of internal medicine in the U.S. Medical educators, researchers, administrators, and providers of health care who have assumed that these two groups of patients are comparable must re-evaluate their practices.

112) **Rudnick, Vincent; Spitzer, Walter O.; & Pierce, John (1976) "Comparison of a Private Family Practice and a University Teaching Practice," *Journal of Medical Education*, Vol. 51, No. 5: 395-402.**

Private practice; university practice; health care

In March 1972 a private family practice in Hamilton, Ontario, became a teaching practice of McMaster University. Subsequently a before-and-after study was conducted to compare characteristics of the patients and the impact of the change on the practice. There was a 34 percent reduction in practice size. There was a shift to younger patients and a substantial drop in mean patient income. Utlization rates of health services rose, particularly hospitalization, even though the average length of stay decreased. Profiles of complaints and diagnoses remained very similar. Quality of care services were comparable with those of community controls before and after the change. Gross income from clinical earnings dropped, but the amounts per person per year were very similar in the two periods. It is concluded that the "transplanted private practice" which becomes part of a school of medicine is a realistic teaching resource in primary care.

113) **Sacks, Joseph A.; Phillips, John; Cappalletty, Gordon (1987) "Characteristics of the Homeless Mentally Disordered Population in Fresno County," *Community Mental Health Journal*, Vol.23, No.2:114-119.**

Homelessness; mental illness; patient characteristics

A survey of a sample comprising 9.5% of the estimated homeless mentally disordered population of Fresno County was conducted as a needs assessment for a treatment program proposal. Eighty percent of the sample were found to meet the criteria for a psychiatric diagnosis as determined by a standardized interview. Of these, 34% were rated severely impaired and urgently in need of treatment. An additional 33% were rated moderately impaired so that treatment would be of substantial benefit. Survey data are presented of the sample's priorities concerning primary needs, preferred locale for treatment and services, type of personnel with whom they would feel most comfortable, and most important problems.

114) **Santiago, Joe M. (1988) *Defining the Homeless Mentally Ill: A Methodological Note.***

Mental illness; homelessness; patient characteristics

This article examines the changes in the distribution of demographic and treatment variables when one definition of homelessness is substituted for another in an analysis of a sampling of individuals receiving emergency psychiatric services in an urban general hospital. The Tucson Homeless Mentally Ill Study was designed to increase understanding of the relationship between homelessness and mental illness by comparing across an array of socioeconomic, demographic, clinical and treatment variables, domiciled and undomiciled general hospital emergency room patients who were referred for psychiatric screening.

115) **Schacter, Lee Phillip & Elliston, Elizabeth P. (1977) "Medical Care in a Free Community Clinic," *Journal of American Medical Association*, Vol. 237, No. 17: 1848-1851.**

Free clinics; patient characteristics; health care

The People's Free Community Clinic in Baltimore is the model for an examination of the relatively new mechanism of health care provision. The six-year survival of the clinic demonstrates that medical care can be provided at a low cost on a continuing basis by volunteer staff (professionals, allied health personnel, and lay people) to low income people in a working class community. Age distribution and types of problems of the patients show that free clinics attract a variety of people, not just those associated with a counterculture. Health care is expensive, the authors suggest an alternative method of finding primary medical care for the poor. Instead of receiving inadequate and often delayed payments, the physician could be allowed to deduct the cost of his services to certified poor directly from his taxes as a charitable contribution.

116) **Schieffenlbein, Carl W. & Snider, Dixie E. (Aug 1988) "Tuberculosis Control Among Homeless Populations," *Archives of Internal Medicine*, Vol. 148, 1843-1846.**

Homelessness; tuberculosis; diseases

The prevalence of tuberculosis infection and disease among homeless persons is high. Several recent outbreaks have been reported in shelters for the homeless. To address this problem,

the Centers for Disease Control, Atlanta, convened a group of consultants who made the following recommendations: 1) Tuberculosis should be suspected and sputum samples should by collected from any homeless individual with a productive cough. 2) Diagnosed or suspected tuberculosis in a homeless individual should be immediately reported to the health department. 3) Therapy should be fully supervised by a responsible person, and an intensive multidrug, six-month regimen should be utilized whenever possible. 4) A contact investigation should be conducted around each infectious case, and preventive therapy should be prescribed for high-risk infected individuals. 5) Shelter staff should receive a tuberculin skin test when they start work and every six to 12 months thereafter. 6) Skin test reactors should be considered for preventive therapy according to reduce transmission should be considered in some situations.

117) **Schein, Leon (Fall 1979) "A Hard-to-reach-population: "Shopping Bag Women," *Journal of Gerontological Social Work*, Vol. 2, No. 1: 29-41.**

Homelessness; women; primary care

Contemporary discussions have begun to focus on "hard-to-reach" populations. One such group, known as "shopping bag women", has disengaged from interpersonal relationships and stable communities. The tentative hypothesis which emerges is that any relationship has within it the seeds of entrapment. As a result, these women do not readily utilize mainstream social agencies. This paper examines how the client's "being in the world" is intergrated within the structure of a temporary shelter specifically for "shopping bag women". The application of social work principles, while maintaining respect for the client's need for anonymity and isolation, has made it possible to provide primary services to individuals for whom living on the street was previously the only alternative.

118) **Schneeweiss, Ronald; Rosenblatt, Roger A.; Cherkin, Daniel C.; Kirkwood, C.Richard; & Hart, Gary (1988) "Diagnosis Clusters: A New Tool for Analyzing the Content of Ambulatory Medical Care," *Medical Care*, Vol. XXI, No. 1: 105-122.**

Diagnosis clusters; ambulatory morbidity data

A clustering method for the analysis of ambulatory morbidity data is presented. This approach reduces spurious variations resulting from idiosyncratic diagnosis labeling and coding habits of physicians and facilitates the analysis of the content of ambulatory medical care through the use of aggregate morbidity data. The clusters provide a tool that allows for the comparison of the content of practice based of different factors such as provided training, practice organization, and patient characteristics. Ninety-two diagnosis clusters were derived using the 1977 and 1978 National Ambulatory Medical Care Survey (NAMCS). These clusters incorporate 86 per cent of all ambulatory visits to office-based physicians in the contiguous United States. The clusters were constructed based on the consensus of a group of clinicians including both generalists, as well as selected subspecialists representing the spectrum of ambulatory medicial practice. The diagnosis clusters presented are compatible with the International Classifications of Health Problems in Primary Care (ICHPPC & ICHPPC-2) and the International Classification of Diseases (ICDA-8 & ICD-9 CM). Several applications demonstrating the utility of the method are presented, and directions for future applications are suggested.

119) **Shah, Chandrakant P.; Kahan, Meldon; & Krauser, John (1987) "The Health of Children of Low-Income Families," *Canadian Medical Association Journal*, Vol. 137, 485-490.**

Poverty; children; health problems

Childhood poverty is common in Canada: 1,114,000 children under 16 years of age live below the poverty line. The incidence is highest among children of single mothers, unemployed parents, Canadian native people and recent immigrants, particulary refugees. Compared with the national average, the infant mortality rate is twice as high, deaths from infectious diseases are 2.5 times more common and accidental deaths are twice as common among children of low-income families. Other problems associated with poverty are iron deficiency anemia, dental cavities, chronic ear infections, mental retardation, learning disabilities, poor school performance and increased suicide rates. Health care professionals can help address the poor physical and mental health associated with poverty in children by promoting a broad range of public policies.

120) **Shane, Paul G. (1989) "Changing Patterns Among Homeless and Runaway Youth," *American Journal of Orthopyschiatry*, Vol. 59, No. 2: 208-214.**

Homelessness; youths; health services

In recent years, the population of runaway and homeless youth has changed. In a study of 536 homeless and runaway youth who were clients of service agencies in New Jersey, homeless youth predominated. Only one-third of the sample were able to return home after service and this particular focus of service is seen as feasible only for a minority of such youth.

121) **Shanks, N.J. (Nov.1981) *Update*, 1197-1202.**

Homelessness; mental health; health problems

This paper discusses the plight of homeless people; their psychiatric aspects and problems of infestation, tuberculosis, alcoholism, peptic ulceration, trauma and epilepsy.

122) **Shapiro, Evelyn & Roos, Noralou P. (1985) "Elderly Nonusers of Health Care Services: Their Characteristics and Their Health Outcomes," *Medical Care*, Vol. 23, No. 3: 247-257.**

Elderly; utilization of health services; access; health care

Sociodemographic, health, and health care utilization data on a large representative sample of the elderly and multiple logistic regression were used to compare persons making no visits to physicians for 2 years with those making few (one to three) visits but in contact with health practioners. Results suggest that elderly nonusers are more likely than low users to be single, to have some degree of mental impairment, and to have low educational attainment. Using Cox's proportional hazards model to compare outcomes over the next 7 years, no differences were found in the subsequent hospitalization rate of the two groups, but nonusers were at a greater risk of a hospitalization episode of 16+ days and appeared to die sooner than low users. However, they were at no greater risk of poor health outcomes than elderly making four or more physician visits in 2 years. The policy implications of the findings are discussed.

123) **Shore, James H. & Kofoed, Lial (Mar-Apr 1984) "Alcoholism Treatment Through Systems Intervention," *A Perspective-Part II*, Vol. 8, No. 2: 151-159.**

Alcoholism; community planning

The authors have chosen five important examples of alcoholism treatment delivery systems that involve major elements of community intervention and social issues. Each example includes individual patient treatment and broader public health-community approaches that are addressed by specific public policy measures. These five examples are 1) driver diversion 2) the public inebriate 3) outpatient and social detoxification 4) alcohol treatment for American Indians 5) treatment of the alcoholic physician. For each area the scientific studies of treatment effectiveness will be reviewed. The major public policy or community intervention initiatives will be discussed.

124) **Slavinsky, Ann T. & Cousins, Ann (June 1982) "Homeless Women," *Nursing Outlook*, 358-361.**

Homelessness; women; stereotypes; emergency shelters

Various myths about homeless women are examined and explained in this article. The reality of these women are also explored and a detail about a shelter for women (Rosie's Place) is looked at.

125) **Smith, Nelson (1985) "Homelessness: Not One Problem, But Many," *Journal Institution for Socio-economic Studies*, Vol. 10, No. 3: 53-67.**

Homelessness; public policy

Homelessness has long been a part of America, what has changed , however, is the nature of the population. No longer is "homeless" a term reserved for Skid Row denizens-i.e. older, white alcoholics each on permanent Lost Weekend. In the past few years, "the homeless" has been identifed as a range of indigents: persons without means, needing food and shelter, often mentally ill, younger than the homeless of another era, and, disproportionately, members of minoriy groups. This change in the composition of the homeless population and the great growth in number, has brought about a dramatic shift in attitudes. Today, it is not just the Salvation Army which cares for the homeless; it is an army of advocates, social service providers, volunteers, and government officials. Homelessness is now a matter of public debate--a debate too much characterized by acrimony and allegations of ill faith.

126) **Snow, David A.; Baker, Susan G.; & Anderson, Leon (June 1986) "The Myth of Pervasive Mental Illness Among the Homeless," *Social Problems*, Vol. 33, No. 5: 407-423.**

Homelessness; mental illness; stereotypes

This paper calls into question the double-edged thesis that the majority of the homeless are mentally ill and the streets of urban America have consequently become the asylums of today. They present data from a triangulated field study of nearly 1000 unattached homeless adults in Texas that contradict this stereotypic imagery. They also suggest that this root image is due to to the medicalization of the problem of homelessness, a misplaced emphasis on the casual role of deinstitutionalization, the heightened visibility of homeless individuals who are mentally ili, and several conceptual and methodological shortcomings of previous attempts to assess the mental status of the homeless. They conclude by arguing that the most common face on the streets is not that of the psychiatrically-impaired individual, but of one caught in a cycle of low-paying, dead-end jobs that fail to provide the means to get off and stay off the streets.

127) **Stoner, Madeleine R. (December 1983) "The Plight of Homeless Women," *Social Service Review*, 565-581.**

Homelessness; women; basic need; public policy

The plight of the homeless population in the United States has recently drawn public attention. This article focuses on the growing number of women among the homeless, their special needs, and the harsher conditions of life for homeless women than for men. It suggests a comprehensive three-tiered service system to address the needs of the homeless population is general, and homeless women specifically, and recommends several courses for political and social action that address systemic causes of homelessness.

128) **Strasser, Judith A. (1978) *Urban Transient Women.***

Homelessness; women; heath problems; patient characteristics

A study of the patients at St.John's, a day shelter offering help to the homeless is discussed. Characteristics include: inappropiate compliance with "official" directives, a fear of men, efforts toward and pride concerning personal hygiene, a fear of dependence, and a desire for autonomy. Most of the women had nutritional aberrations, severity/number of health problems, conditions, present health practices and ethnic beliefs, low rate of alcoholism.

129) **Surber, Robert W.; Dwyer, Eleanor; Ryan, Katherine J.; Goldfinger, Stephen M.; & Kelly, John T. (Mar.-Apr. 1988) *Social Work*, Vol. 33, No. 2: 116-119.**

Homelessness; health care; mental health

The results of two surveys that assessed the medical and psychiatric needs of the homeless in San Fransisco are discussd. A program designed to meet the needs of this population is described, and further programmatic and policy considerations to respond to the problem of homelessness are advocated.

130) **Taube, Carl A.;Burns, Barbara J.; Kessler, Larry G.; & Goldman, Howard G. (Jan 1988) "High Users of Outpatient Mental Health Services, I: Definition and Characteristics," *American Journal of Psychiatry*, Vol. 145, No. 1: 19-24.**

Mental health; patient characteristics; utilization of health services

Mental health coverage generally limits benefits for high use, which is assumed to be discretionary. The authors present data from the National Medical Care Utilization and Expenditure Survey. Of the individuals who made mental health outpatient visits in 1980, 9.4% made 25 or more visits and accounted for 50% of mental health visits and expenditures. These high users were compared with low users and with high users of other health care. One-third of the mental health high users were highly disabled and had multiple medical disorders. The authors point out the heterogeneity of this population and suggest that psychiatric benefits be differentiated according to patients's needs and services offered.

131) **Taylor, Timothy L. (1988) "Health Problems and Use of Services at Two Urban American Indian Clinics," *Health Reports*, Vol. 103, No. 1: 88-95.**

Health services; Native Indians; health problems

The use of primary health care services by urban American Indians and their health problems were compared with national and regional data complied by the Indian Health Service, Bureau of the Census, Office of the Technology Assessment, and the National Center for Health Statistics. A survey of medical records was conducted at urban Indian health clinics, one was located in Oklahoma City, OK, and the other in Wichita, KS. Health records of 500 patients from each clinic were reviewed. Information was gathered concerning reasons for visit, diagnoses, and number of physician visits. In addition, predisposing variables and enabling variables from each patient's registration form were reviewed.

According to the data collected in the survey, the clientele of these urban Indian clinics have annual incomes well below the average income of the general population and the overall American Indian population in these cities. Their lack of health insurance and low education levels were also evident. Use of primary health services was below that of the general population, and lower, but relatively close, to use levels of American Indians residing in rural Oklahoma and Kansas. Information on health problems indicated high levels of diabetes mellitus and hypertension among the middle-age groups, and high levels of use by young women for prenatal care and contraception.

The absence of systematically collected and comprehensive health and health care use information about urban American Indians, who now comprise more than half the American Indian population, and the limitations in the available information leave important questions unanswered. There are indications that large segments of urban Indian populations have difficulty obtaining primary and preventive health care services due to their general socioeconomic condition and the absence of the Indian Health Service in many urban areas.

132) **Torres, Ramon A.; Lefkowitz, Pearl; Kales, Christopher; & Brickner, Philip W. "Homelessness Among Hospitalized Patients With the Acquired Immunodeficiency Syndrome in New York City," *Journal of American Medical Associations (Letters)*, Vol. 258, No. 6: 779-780.**

Homelessness; AIDS; hospital population

Homelessness has become a problem for many patients with the acquired immunodeficiency syndrome (AIDS), as well as for the health care provision system in New York City. To determine the prevalence of homelessnes among hospitalized AIDS patients, they retrospectively reviewed the medical records of all patients (a total of 231) in whom the diagnosis of AIDS was made at the hospital over a four-year period (November 1981 to October 1985).

133) **Wilberg, Janice K. (1986) "Doing What's Right: Public Policy and Indigent Health Care in Milwaukee County," *Dissertation Abstracts International*, Vol. 47, No. 7.**

Health care; public policy; stereotype

This is a case study examining the public policy response to the fiscal pressures of 1981-83 period relative to the provision of county-funded indigent health care. It It It examines conditions between traditional policies toward medically indigent and the political realities of heightened demand, higher costs, and the reduced revenues. The focus of the study is how policymakers' perception about the poor, their entitlement to free care, and the boundaries of government responsibility dictated the range of viable policy alternatives.

134) **Windle, Charles Poppen, Paul J.; Thompson, James W.; & Marvelle, Kevin (1988) "Types of Patients Served by Various Providers of Outpatient Care in CMHCs," *American Journal of Psychiatry*, Vol. 145, No. 4: 457-463.**

Mental health; patient characteristics; physician-patient encounters

Representative community mental health center (CMHC) survey data showed that psychiatrists differed from other CMHC providers of mental health services by serving the more seriously impaired patients who are admitted and readmitted to outpatient services. Psychiatrists also shared more outpatients with providers from other disciplines than providers in other disciplines shared with one another. The results are consistent with previous research on differences between disciplines and with the flight of pyschiatrists from CMHCs but cast doubt on the hypothesis that psychiatrists see sicker patients than pyschologists see because of differences in reimbursement between the two disciplines.

135) **Woodward, Christel A.;Boyle, Michael H.; Offord, David R.; Cadman, David T.; Links, Paul S. Munroe-Blum, Heather; Byrne, Carlyn & Thomas, Helen (1988) "Ontario Child Health Study: Patterns of Ambulatory Medical Care Utilization and Their Correlates," *Pediatrics*, Vol. 82, No. 3: 425-434.**

Children; ambulatory care; utilization of health services

Data from a large epidemiologic survey of Ontario children 4 to 16 years of age are presented concerning the frequency and correlates the use of ambulatory medical care services during a 6-month period in which a universal, first-dollar health insurance plan was used. Patterns of use of ambulatory medical care are described for three settings: doctor's offices, emergency rooms, and hospital outpatient departments. A group of children who are frequent users of ambulatory medical care (defined as using three or more services in 6 months) consumed nearly two thirds of all services. Two regression equations are presented-one predicting use/nonuse and amount of ambulatory medical care and the other predicting the total number of visits for medical care. Although only a small proportion of the variance in use/nonuse and amount of use was explained, the major determinant of both ambulatory medical care use and frequency of use wsa the child's physical health status as perceived by the parent. Younger child, urban areas of residence, the number of chronic medical problems of the child, and higher level of maternal education also contributed to the explanation of use versus nonuse. Among ambulatory medical care users, high users were more likely to be described as having mental health problems and have parents who have been treated for "nerves". Family size and socioeconomic variables were not important factors in use, suggesting that universal health insurance reduces some barriers to ambulatory medical health care for children.

136) **Wright, J.D.; Rossi, P.H.; Knight, J.W.; Weber-Burdin, E.; Tessler, R.C.; Stewart, C.E.; Geronimo, M.; & Lam, J. (1987) "Homelessness and Health: The Effects of Life Style on Physical Well-Being Among Homeless People in New York City," *Research in Social Problems and Public Policy*, Vol.4:41-72.**

Homelessness; health problems

This article discusses the plight of homeless people in America and the many factors that have postulated to account for the rise of numbers in this group. There is a focus on physical health

problems from data consisting of information gleaned from clinical class of patients in two hospitals in New York City. Risk factors that account for the observed epidemiology of disease among the homeless include demographic factors, behavioral factors, environment and life style. From the analyses, principal conclusions can be drawn. The demographic composition of the homeless in New York City appears to have changed substantially in the past 15 years; the population now is much younger on the average; better educated; dominated by blacks and Hispanics; less substance abuse; and a sizable portion are women. The "new homeless" are clearly a different breed in demographic terms. Despite the declining rate of alcohol abuse, this remains a serious health problem among the homeles. Accordingly, diseases and disorders known to be related to alcohol are also quite common. All previous studies have reported that poor mental health is a serious problem among the homeless. Nothing in the results we have complied contradicts this conclusion. The epidemiology of disease among the homeless provides an apt illustration of the effects of lifestyle on physical health.

137) **Youssef, Fatma A.; Omokehinde, Maize; Garland, Iven M. (1988) "The Homeless and Unhealthy: A Review and Analysis,"** ***Issues in Mental Health Nursing*****, Vol. 9, 317-324.**

Homelessness; mental health; public polices

Homelessness is a persistent problem in the United States that has rapidly grown into a major societal tragedy which receives increasing attention from the public, media, and government. Comprising a large group of individuals who are vulnerable to disease, crime, and victimization, the homeless are estimated to number about two million. Almost half are suffering from alcohol abuse, drug abuse, or mental health problems. Survey data and evaluations of mental health outreach programs have raised basic questions about the responsibilities of policymakers and service providers. Improved systems of coordinated services and case management should be designed to link the homeless population and the larger service delivery system. Establishing this link within a model community service program is recommended.

138) **Yukl, Trudy (Summer 1986) "Cultural Responsiveness and Social Work Practice: An Indian Clinic's Success,"** ***Health and Social Work*****, 223-229.**

Cross-cultural differences; Native Indians; health services

Social workers need to appreciate the traditions and beliefs of clients from different cultures to provide effective services. The success of one hospital clinic in serving American Indians in Boston demostrates how this appreciation can be translated into programs that are revelant to a particular population or targeted group.

139) **Yunker, Rose M.; Levine, Martha K.; & Sajid, Abdul W. (1985) "Freestanding Emergency Centers and the Patient Population of Family Physicians,"** ***Journal of Family Practice*****, Vol. 21, No. 1: 63-69.**

Family practice clinics; health care; emergency centers

To determine whether the petients of free-standing emergency centers are similiar to the patients seen by family physicians, the age, sex, time of visit, diagnoses, laboratory work, and charges for 1,062 patients from two free-standing emergency centers were compared with available data on the patients seen by a national sample of family physicians. Patients from the emergency centers were predominantly in the 20-to-40-year age range(73.8%), were male (56.5%), and sought trauma-related treatment or medical examinations (51.7%).Laboratory tests were ordered for 30.2% of these patients. In contrast, family practice patients were more evenly distributed by age, were more often female (57.6%), and had a wide variety of diagnoses. Laboratory tests were ordered for 40.3% of the patients. The median free-standing emergency center charge was approximately $10 higher than initial visit fees to family physicians in the same area.

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